No. 05-1382
Title: Alberto R. Gonzales, Attorney General, Petitioner
v.
Planned Parenthood Federation of America, Inc., et al.
Docketed: May 2, 2006
Lower Ct: United States Court of Appeals for the Ninth Circuit
Case Nos.: (04-16621)
Decision Date: January 31, 2006
Questions Presented

Date	Proceedings and Orders
May 1 2006	Petition for a writ of certiorari filed. (Response due June 1, 2006)
May 1 2006	Appendix of Alberto R. Gonzales, Attorney General filed.
May 12 2006	Brief of Planned Parenthood Respondents filed.
May 12 2006	Brief of respondent City and County of San Francisco filed.
May 23 2006	DISTRIBUTED for Conference of June 8, 2006.
May 25 2006	Reply of petitioner Alberto R. Gonzales, Attorney General filed. (Distributed)
Jun 5 2006	Supplemental brief of respondents Planned Parenthood Respondents filed. (Distributed)
Jun 12 2006	DISTRIBUTED for Conference of June 15, 2006.
Jun 19 2006	Petition GRANTED.
Aug 1 2006	Extension of time within which to file respondents' brief on the merits to and including September 27, 2006.
Aug 1 2006	Brief amicus curiae of Right to Life Advocates, Inc. filed.
Aug 2 2006	Brief amicus curiae of Thomas More Society, Inc. filed.
Aug 2 2006	Brief amici curiae of American Association of Pro Life Obstetricians and Gynecologists, et al. filed.
Aug 2 2006	Extension of time within which to file respondents' brief on the merits to and including September 27, 2006.
Aug 3 2006	Joint appendix filed. (Joint appendix in six volumes.)
Aug 3 2006	Brief of petitioner Alberto R. Gonzales, Attorney General filed.
Aug 3 2006	Brief amicus curiae of Professor Hadley Arkes and Claremont Institute Center for Constitutional Jurisprudence filed.
Aug 3 2006	Motion for leave to file Volume VI of the joint appendix under seal filed by the Solicitor General.
Aug 3 2006	Brief amici curiae of Faith and Action, et al. filed.
Aug 3 2006	Motion to allow counsel, or Guardian Ad Litem, to represent children unborn and born alive filed by Alan Ernest.
Aug 3 2006	Brief amicus curiae of Legal Defense for Unborn Children in support of neither party filed.
Aug 3 2006	Brief amicus curiae of American Center for Law & Justice filed.
Aug 3 2006	Brief amici curiae of Christian Legal Society, et al. filed.
Aug 3 2006	Brief amicus curiae of National Legal Foundation filed.
Aug 3 2006	Brief amici curiae of Matercare International, et al. filed.
Aug 4 2006	Copies of court of appeals record excerpts received from the Solicitor General.

Aug 8 2006	Motion of Christian Medical and Denta! Associations, and the Catholic Medical Associations for leave to file brief amici curiae out of time filed.
Aug 9 2006	Motion for leave to file Volume VI of JA under seal DISTRIBUTED for Conference of September 25, 2006.
Aug 10 2006	Brief amici curiae of Statisticians Professor George W. Cobb, et al. filed. VIDED.
Aug 10 2006	Brief amici curiae of Constitutional Law Professors, David L. Faigman and Ashutosh A. Bhagwat, et al. filed. VIDED.
Aug 14 2006	SET FOR ARGUMENT on Wednesday, November 8, 2006.
Aug 14 2006	CIRCULATED.
Aug 30 2006	Application (06A240) of petitioner to file a consolidated reply brief exceeding the page limits or, in the alternative, to extend the time to file a reply brief in No. 05-380, submitted to Justice Kennedy. VIDED.
Sep 1 2006	Motion to allow counsel, or Guardian Ad Litem, to represent children unborn and born alive DENIED.
Sep 1 2006	Motion for leave to file amicus brief out of time filed by Ronald W. Meyer. (Distributed)
Sep 6 2006	Application (06A240) of petitioner to file a consolidated reply brief on the merits in excess of the page limitation granted by Justice Kennedy provided that the brief does not exceed 30 pages and that it is filed on or before 35 days from the date on which respondents in No. 05-1382 file their brief on the merits.
Sep 18 2006	Brief amici curiae of Naral Pro-Choice America Foundation, et al. filed. (Distributed)
Sep 20 2006	Reply of respondent Intervenor-Respondent City and County of San Francisco filed. (Distributed)
Sep 20 2006	Brief of Planned Parenthood Respondents filed. (Distributed)
Sep 20 2006	Brief amici curiae of National Women's Law Center, et al. filed. (Distributed)
Sep 20 2006	Brief amici curiae of Institute for Reproductive Health Access and Fifty-Two Clinics and Organizations filed. (Distributed)
Sep 20 2006	Brief amici curiae of Religious Coalition for Reproductive Choice, et al. filed. (Distributed)
Sep 20 2006	Brief amici curiae of American Civil Liberties Union, et al. filed. (Distributed)
Sep 20 2006	Brief amicus curiae of California Medical Association filed. (Distributed)
Sep 20 2006	Brief amicus curiae of Former Federal Prosecutors filed. (Distributed)
Sep 20 2006	Brief amici curiae of American Medical Women's Association, American Public Health Association, et al. filed. (Distributed)
Sep 20 2006	Brief amici curiae of 52 Members of Congress filed. (Distributed)
Sep 20 2006	Record received from U.S.C.A. for 9th Circuit. (1 envelope)
Sep 20 2006	Brief amicus curiae of American College of Obstetricians and Gynecologists filed. VIDED. (Distributed)
Sep 22 2006	DISTRIBUTED for Conference of September 25, 2006.
Sep 22 2006	Record received from U.S.D.C. for Northern District of California. (2 boxes)
Oct 2 2006	Motion for leave to file amicus brief filed by Christian Medical and Dental Associations, and the Catholic Medical Associations GRANTED.
Oct 2 2006	Motion for leave to file amicus brief out of time filed by Ronald W. Meyer DENIED.
Oct 2 2006	Motion for leave to file Volume VI of the joint appendix under seal GRANTED.
Oct 25 2006	Reply of petitioner Alberto R. Gonzales, Attorney General filed. VIDED. (Distributed)

Supreme Court, U.S.
FILED

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OFFICE OF THE CLERK

No.

In the Supreme Court of the United States

ALBERTO R. GONZALES, ATTORNEY GENERAL,
PETITIONER

v.

PLANNED PARENTHOOD FEDERATION
OF AMERICA, INC., ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

The Partial-Birth Abortion Ban Act of 2003 (the Act), Pub. L. No. 108-105, 117 Stat. 1201 (to be codified at 18 U.S.C. 1531), prohibits a physician from knowingly performing a "partial-birth abortion" (as defined in the statute) in or affecting interstate commerce. § 3, 117 Stat. 1206-1207. The Act contains an exception for cases in which the abortion is necessary to preserve the life of the mother, but no corresponding exception for the health of the mother. Congress, however, made extensive factual findings, including a finding that "partial-birth abortion is never medically indicated to preserve the health of the mother." § 2(14)(O), 117 Stat. 1206. The question presented is as follows:

Whether, notwithstanding Congress's determination that a health exception was unnecessary to preserve the health of the mother, the Partial-Birth Abortion Ban Act of 2003 is invalid because it lacks a health exception or is otherwise unconstitutional on its face.

PARTIES TO THE PROCEEDING

Petitioner is Alberto R. Gonzales, Attorney General of the United States. Respondents are Planned Parenthood Federation of America, Inc.; Planned Parenthood Golden Gate; and the City and County of San Francisco.

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PETITION FOR A WRIT OF CERTIORARI

The Solicitor General, on behalf of the Attorney General of the United States, respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-54a) is reported at 435 F.3d 1163. The order of the district court (Pet. App. 55a-218a) is reported at 320 F. Supp. 2d 957.

JURISDICTION

The judgment of the court of appeals was entered on January 31, 2006. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

This case presents a facial challenge to the constitutionality of the federal Partial-Birth Abortion Ban Act of 2003 (the Act), Pub. L. No. 108-105, 117 Stat. 1201 (to be codified at 18 U.S.C. 1531). On February 21, 2006, the Court granted certiorari in *Gonzales* v. *Carhart*, No. 05-380, to resolve the constitutionality of the same Act. This petition for certiorari therefore should be held pending the decision in *Carhart* and disposed of accordingly.

1. The factual background to Congress's enactment of the Act is set forth in greater detail in the statement of the government's petition for certiorari in *Carhart*. The phrase "partial-birth abortion" is commonly used to describe a late-term abortion procedure known interchangeably as dilation and extraction (D&X) or intact dilation and evacuation (intact D&E), in which a physician partially delivers the fetus intact (*i.e.*, without first dismembering it) and then kills the fetus, typically by puncturing its skull and vacuuming out its brain. After years of hearings and debates, Congress passed, and the President signed, the Partial-Birth Abortion Ban Act of 2003. In drafting the Act, Congress deliberately sought to remedy the deficiencies identified by this Court in the state partial-birth abortion statute that the Court invalidated in *Stenberg* v. *Carhart*, 530 U.S. 914 (2000).

First, the federal Act contains a more precise definition of the phrase "partial-birth abortion" than the stat-

ute at issue in *Stenberg*. Specifically, it defines a "partial-birth abortion" as:

> an abortion in which the person performing the abortion—(A) deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and (B) performs the overt act, other than completion of delivery, that kills the partially delivered living fetus.

Act § 3, 117 Stat. 1206-1207 (to be codified at 18 U.S.C. 1531(b)(1)). The Act imposes criminal and civil sanctions only on a physician who "knowingly" performs such an abortion. § 3, 117 Stat. 1206 (to be codified at 18 U.S.C. 1531(a)). Like the statute at issue in *Stenberg*, the Act includes an exception for any cases in which a partial-birth abortion is necessary to preserve the life of the mother. *Ibid.*

Second, based on "the testimony received during extensive legislative hearings during the 104th, 105th, 107th, and 108th Congresses," Act § 2(14), 117 Stat. 1204, the Act contains extensive factual findings concerning the medical necessity of partial-birth abortion, culminating in the ultimate finding that "partial-birth abortion is never medically indicated to preserve the health of the mother," § 2(14)(O), 117 Stat. 1206. Among its subsidiary findings, Congress determined that "[t]here is no credible medical evidence that partial-birth abortions are safe or are safer than other abortion procedures," § 2(14)(B), 117 Stat. 1204, and that

"[p]artial-birth abortion poses serious risks to the health of a woman undergoing the procedure," § 2(14)(A), 117 Stat. 1204. Although Congress acknowledged that the district court in *Stenberg* had made contrary factual findings, Congress noted that much of the evidence on which it was relying in making its own findings was not contained in the *Stenberg* record. § 2(5)-(8), 117 Stat. 1202.

2. Respondents brought suit against the Attorney General, seeking a declaration that the Act is unconstitutional on its face and a permanent injunction against enforcement of the Act. Respondents contended that the Act was facially invalid under the Fifth Amendment because (1) it lacked a health exception; (2) it otherwise imposed an undue burden on a woman's access to an abortion because it prohibited not only D&X abortions, but also other types of abortions; and (3) it was unconstitutionally vague in various respects.

After a bench trial, the district court granted judgment to respondents and entered a permanent injunction. Pet. App. 55a-218a. The district court agreed with respondents that the Act was facially invalid on all three asserted grounds. Most significantly, the court held that the Act was facially invalid because it lacked a health exception. *Id.* at 96a-217a. The court rejected the government's argument that Congress's factual findings concerning the medical necessity of partial-birth abortion were entitled to deference on the ground that, under *Stenberg*, the relevant question was whether "significant medical authority supports the proposition that in some circumstances, [intact D&E] is the safest procedure." *Id.* at 214a (citation omitted). The court determined, *inter alia*, that "there continues to be a division of opinion among highly qualified experts regarding the

necessity or safety of intact D&E," *id.* at 215a, and on that basis refused to defer to Congress's ultimate finding that partial-birth abortion was never medically indicated to preserve the health of the mother, *id.* at 212a. The district court also held that the Act was facially invalid on the ground that it imposed an undue burden on a woman's access to an abortion by reaching "several second trimester abortion procedures in addition to intact D&E," *id.* at 85a; see *id.* at 73a-89a, and on the ground that it was unconstitutionally vague because it "fail[ed] to clearly define the prohibited medical procedures and d[id] not use terminology that is recognized in the medical community," *id.* at 89a; see *id.* at 89a-96a. The district court thus permanently enjoined the government from enforcing the Act against respondents and their employees. *Id.* at 218a.

3. The court of appeals affirmed. Pet. App. 1a-54a.

The court of appeals first held that the Act was facially invalid because it lacked a health exception. Pet. App. 14a-22a. The court construed this Court's decision in *Stenberg* as holding that "an abortion regulation that fails to contain a health exception is unconstitutional except when there is a medical consensus that no circumstance exists in which the procedure would be necessary to preserve a woman's health." *Id.* at 15a. The court of appeals acknowledged that Congress had made various factual findings concerning the necessity of a health exception. *Id.* at 17a. Nevertheless, it held that, "[u]nder even the most deferential level of review," Congress's *threshold* finding that "[a] moral, medical, and ethical consensus exists that the practice of performing a partial-birth abortion * * * is never medically necessary," Act § 2(1), 117 Stat. 1201, would not be entitled to deference. Pet. App. 19a. The court thus rejected the

government's submission that the relevant question was whether deference was owed to Congress's *ultimate* finding that "partial-birth abortion is never medically indicated to preserve the health of the mother," Act § 2(14)(O), 117 Stat. 1206. Pet. App. 21a-22a.

Although the court of appeals' ruling that "Congress's failure to include a health exception in the statute renders the Act unconstitutional," Pet. App. 22a, was a sufficient basis to affirm the district court, the court went on to hold that the Act was facially invalid on the alternative grounds that it imposed an undue burden on a woman's access to an abortion (because it reached some other types of abortions besides D&X abortions) and that it was unconstitutionally vague (because it contained ambiguous language that arguably reached some other types of abortions). *Id.* at 23a-40a.

The court of appeals further held that the Act should be enjoined in its entirety. Pet. App. 40a-54a. As a preliminary matter, the court hypothesized that, if the Act were facially invalid solely because it lacked a health exception, the court "might have been able to draft a more 'finely drawn' injunction." *Id.* at 41a. The court nevertheless reasoned, however, that a narrower injunction would not have been appropriate even in that instance, because such an injunction would be inconsistent with Congress's intent in promulgating the Act. *Ibid.* The court explained that, in its view, the Act's sponsors believed that the Act would have little force or effect if it contained a health exception. *Id.* at 44a.

The court of appeals concluded, however, that "we need not rest our decision as to the appropriate remedy solely on the omission of a health exception" because the Act was also unconstitutional on other grounds. Pet. App. 47a. To remedy all the asserted constitutional defi-

ciencies, the court contended, it would "in effect have to strike the principal substantive provision that is now in the Act," leaving a statute that was substantially different from (and narrower than) the one that Congress enacted. *Ibid.* The court of appeals therefore concluded that "the appropriate remedy" was "to enjoin the enforcement of the statute in its entirety." *Id.* at 54a.

REASONS FOR GRANTING THE PETITION

The Ninth Circuit held that the Partial-Birth Abortion Ban Act of 2003 was facially invalid and permanently enjoined the government from enforcing the Act. The Court has already recognized the importance of the issues raised by such a ruling by granting certiorari in *Gonzales* v. *Carhart*, No. 05-380, to resolve the constitutionality of the Act. The court of appeals in *Carhart* held that the Act was facially invalid because it lacked a health exception—the primary ground on which the Act was challenged below—and therefore did not address the other arguments raised to challenge the Act's constitutionality. As the government explained in its supplemental brief in support of certiorari in *Carhart* (at 8-9 & n.2), however, *Carhart* would permit the Court to address both the necessity of a health exception and the other principal challenges to the Act—including the alternative grounds on which the Ninth Circuit relied below—if the Court chose to do so, because the *Carhart* plaintiffs have preserved those arguments. Likewise, as explained in the government's supplemental brief in *Carhart* (at 9-10), the Court could exercise its discretion to reach the remedial question in *Carhart* if it holds the Act unconstitutional in any respect.

Because *Carhart* presents a suitable vehicle for the Court to resolve the primary facial challenges that have

been made to the constitutionality of the Act, and because the merits briefing is already underway in *Carhart* (the government's opening brief is due May 22, 2006), the petition for a writ of certiorari in this case should be held pending the Court's decision in *Carhart*, and then disposed of as appropriate in light of that decision. If the Court were to determine, however, that plenary review would be appropriate in this case as well as in *Carhart*, the cases should be consolidated for oral argument.

CONCLUSION

The petition for a writ of certiorari should be held pending this Court's decision in *Gonzales* v. *Carhart*, No. 05-380, and then disposed of accordingly.

Respectfully submitted.

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ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

APPENDIX TO THE PETITION FOR A WRIT OF CERTIORARI

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APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 04-16621

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.; PLANNED PARENTHOOD GOLDEN GATE, PLAINTIFFS-APPELLEES

v.

ALBERTO R. GONZALES, ATTORNEY GENERAL OF THE UNITED STATES, IN HIS OFFICIAL CAPACITY, DEFENDANT-APPELLANT

v.

CITY AND COUNTY OF SAN FRANCISCO, PLAINTIFF-INTERVENOR-APPELLEE

Argued and Submitted Oct. 20, 2005
Filed Jan. 31, 2006

Before REINHARDT, THOMAS, and W. FLETCHER, Circuit Judges.

REINHARDT, Circuit Judge.

This appeal presents a challenge to the constitutionality of the Partial-Birth Abortion Ban Act of 2003, Pub. L. No. 108-105, 117 Stat. 1201 (codified at 18 U.S.C. § 1531). We, like every other federal court that has considered the question, conclude that both the Constitution and the law as established by the Supreme Court require us to hold the Act unconstitutional. Unlike the other courts, however, we do so after fully

considering the Supreme Court's recent decision in *Ayotte v. Planned Parenthood of N. New England*, —— U.S. ——, 126 S. Ct. 961, —— L. Ed. 2d —— (2006). In light of *Ayotte*, we conclude that the only appropriate remedy is to enjoin enforcement of the Act and we now affirm the district court's grant of a permanent injunction.

I. Background

A. Post-First Trimester Abortion Methods

The vast majority of abortions in the United States are performed during the first trimester.[1] Approximately ten percent of abortions are performed during the second trimester. Only about one percent are performed after the twentieth week from the woman's last menstrual period ("lmp") and only a small portion of those after the twenty-fourth week, the earliest time at which viability begins. In short, only a tiny percentage of abortions are performed after viability may have commenced.

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[1] The first trimester lasts until the thirteenth or fourteenth week of pregnancy, measured from the woman's last menstrual period ("lmp"). *Planned Parenthood Fed'n of Am. v. Ashcroft*, 320 F. Supp. 2d 957, 960 (N.D. Cal. 2004); *see also Stenberg v. Carhart*, 530 U.S. 914, 923, 120 S. Ct. 2597, 147 L. Ed. 2d 743 (2000) (measuring the first trimester at twelve weeks gestational age, which equals fourteen weeks lmp after adding the approximately two weeks between menstruation and conception). The second trimester lasts until approximately the twenty-seventh week lmp (twenty-four weeks gestational age), with the third culminating in birth (typically at forty weeks lmp). *Planned Parenthood*, 320 F. Supp. 2d at 960. A fetus is generally understood to have achieved viability—meaning that there exists a realistic potential for long-term survival outside the uterus—at twenty-four weeks lmp or later. *Id.*

Women seek abortions after the first trimester for various reasons, including newly discovered fetal anomalies and maternal health problems that are created or exacerbated by the pregnancy. This is primarily because ultrasound and amniocentesis—procedures that often detect these medical conditions—generally are not available until the second trimester. Because abortions are rarely performed after the twenty-fourth week lmp and even more rarely after the second trimester (in both cases almost always for medical reasons), the Act essentially regulates previability second trimester abortions.

Nearly all post-first trimester abortions are performed using one of two methods: dilation and evacuation ("D & E") or induction.[2] D & E accounts for 85 to 95 percent of such abortions. Unlike induction, which is a form of "medical" abortion, D & E is a surgical procedure involving two steps: dilation of the cervix and surgical removal (evacuation) of the fetus. There are two forms of D & E, intact and non-intact.[3]

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[2] Two additional methods are available but are used exceedingly rarely, usually only in an emergency: hysterotomy, which resembles a caesarean delivery through the abdomen; and hysterectomy, which involves complete removal of the woman's uterus with the fetus inside. *Stenberg*, 530 U.S. at 987 n.7, 120 S. Ct. 2597.

[3] Some doctors reject the characterization of intact and non-intact D & E as two separate forms of the D & E procedure. Rather, they believe that there is only a single form which is sometimes performed in a manner that differs from other implementations, but in a way that is of no medical consequence.

Other doctors choose not to label the intact and non-intact procedures as forms of D & E for a different linguistic reason. These doctors reserve the term D & E for the non-intact procedure and call intact removals "dilation and extractions" ("D & X"). D & X is

The first step of the procedure, cervical dilation, is the same for both forms of D & E. It is achieved primarily through the use of osmotic dilators, which are sponge-like devices that expand the cervix, typically over a period of twenty-four to forty-eight hours. Some doctors also use medications known as prostaglandins in conjunction with the osmotic dilators, though these drugs sometimes induce labor spontaneously, which results in partial or complete expulsion. The dilation process is necessary so that the doctor may insert an instrument, generally a type of forceps, through the cervix and into the uterus in order to remove the fetus.

The second step of the procedure, the evacuation phase, is when the two forms of D & E become different.[4] When performing a non-intact D & E, the doctor, under ultrasound guidance, grasps a fetal extremity with forceps and attempts to bring the fetus through the cervix. At this point, the fetus will ordinarily disarticulate, or break apart, because of traction from the cervix, and the doctor must return the instrument to make multiple passes into the uterus to remove the remaining parts of the fetus, causing further disarticulation. To complete the removal process, the doctor evacuates the placenta and any remaining material

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the nomenclature used in *Stenberg*. 530 U.S. at 927, 120 S. Ct. 2597.

The labeling of the procedure is of no consequence to our analysis; however, for simplicity's sake we prefer intact and non-intact D & E. What is relevant, however, is that one could substitute D & X for intact D & E wherever the latter term appears in our opinion and nothing would change in any respect.

[4] In either form of D & E, the removal procedure usually lasts ten to fifteen minutes, during which the woman receives either conscious sedation or general anesthesia.

using a suction tube, or cannula, and a spoon-like instrument called a curette.

In an intact D & E, the doctor, rather than using multiple passes of the forceps to disarticulate and remove the fetus, removes the fetus in one pass, without any disarticulation occurring (i.e., the fetus is "intact"). An intact D & E proceeds in one of two ways, depending on the position of the fetus in the uterus. If the fetus presents head first (a vertex presentation), the doctor first collapses the head, either by compressing the skull with forceps or by inserting surgical scissors into the base of the skull and draining its contents. The doctor then uses forceps to grasp the fetus and extracts it through the cervix.[5] If the fetus presents feet first (a breech presentation), the doctor begins by grasping a lower extremity and pulling it through the cervix, at which point the head typically becomes lodged in the cervix. When that occurs, the doctor can either collapse the head and then remove the fetus or continue pulling to disarticulate at the neck. (If the doctor uses the latter option, he will have to use at least one more pass of the forceps to remove the part of the fetus that remains, and the procedure is not considered an intact D & E.)

As the district court found, some doctors prefer to use the intact form of D & E, whenever possible, because they believe it offers numerous safety advantages over non-intact D & E. As the district court also found, intact D & E may be significantly safer than other D & E procedures because it involves fewer instrument passes, a shorter operating time and consequently less

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[5] In some cases, doctors will convert a fetus that presents head first into the breech position before beginning the evacuation.

bleeding and discomfort for the patient, less likelihood of retained fetal or placental parts that can cause infection or hemorrhage, and little or no risk of laceration from bony fetal parts. Finally, as the district court found, intact D & E is in fact the safest medical option for some women in some circumstances. For example, women with specific health conditions and women who are carrying fetuses with certain abnormalities benefit particularly from the availability of the intact D & E procedure.

According to the American College of Obstetricians and Gynecologists ("ACOG"), the safety advantages offered by intact D & E mean that in certain circumstances it "may be the best or most appropriate procedure . . . to save the life or preserve the health of a woman."[6] Doctors typically decide whether to attempt an intact D & E based primarily on the amount of cervical dilation, but they can never predict beforehand whether they will be able ultimately to remove the fetus intact. In most cases, intact D & E is not an option from the outset; in others, although the proce-

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[6] The primary alternative to the D & E procedures is induction, which comprises approximately 5 percent of abortions performed between weeks fourteen and twenty and 15 percent of abortions performed after the twentieth week. Many doctors consider inductions less safe than D & Es. When employing this procedure, the doctor starts an IV and uses a prostaglandin suppository (or a saline injection) to induce uterine contractions and labor. The entire process takes between eight and seventy-two hours, with most inductions concluding within twenty-four hours. Some inductions will not completely expel the fetus, requiring the doctor to perform a D & E to finish the procedure. Although a D & E may be performed in an outpatient setting, a woman choosing to undergo induction must be admitted to a hospital.

dure may start out as an intact removal, during the course of the procedure it turns into a non-intact D & E.

As explained further below, the government construes the Act as prohibiting intact D & Es but permitting non-intact D & Es, whereas the plaintiffs assert that it covers both forms of the procedure, as well as induction. The plaintiffs also contend that even if the Act banned only intact D & Es, it would still be unconstitutional.

B. The Statute

Enacted in response to the Supreme Court's decision in *Stenberg v. Carhart*, 530 U.S. 914, 120 S. Ct. 2597, 147 L. Ed. 2d 743 (2000), which declared a Nebraska statute regulating "partial-birth abortions" unconstitutional, the Act subjects any physician who "knowingly performs a partial-birth abortion" to civil and criminal penalties, including up to two years of incarceration. 18 U.S.C. § 1531(a) (2005).[7] The Act's definition of "partial-birth abortion" covers an abortion performed by any doctor who:

> (A) deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech pres-

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[7] Before passing the Act at issue here, Congress passed two similar bans, in 1996 and 1998, but President Clinton vetoed both of them and Congress did not override those vetoes. *See* 142 CONG. REC. H3338 (daily ed. Apr. 15, 1996); 144 CONG. REC. S10564 (daily ed. Sept. 18, 1998). In support of the earlier legislation and the Act at issue here, Congress held sporadic hearings on the issue of "partial-birth abortion," and received a number of statements of policy from individuals and organizations that it included in the Congressional Record.

> entation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and
>
> (B) performs the overt act, other than completion of delivery, that kills the partially delivered living fetus.

18 U.S.C. § 1531(b)(1). Doctors who perform a "partial-birth abortion" are exempt from criminal liability only when the procedure is "necessary to save the life of a mother whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself." 18 U.S.C. § 1531(a). The Act does not contain an exception for abortions that are necessary to preserve the health of the woman.

Congress made several findings of fact in support of its determination that the Act's prohibition did not require a health exception. Partial-Birth Abortion Ban Act § 2(8)-(13). Most significant, Congress found that:

> There exists substantial record evidence upon which Congress has reached its conclusion that *a ban on partial-birth abortion is not required to contain a 'health' exception, because the facts indicate that a partial-birth abortion is never necessary to preserve the health of a woman*, poses serious risks to a woman's health, and lies outside the standard of medical care.

Id. at § 2(13) (emphasis added). Another of Congress's central findings was that a "moral, medical and ethical

consensus" exists that intact D & E is "never medically necessary and should be prohibited." *Id.* at § 2(1).[8]

C. The Litigation

Directly after President George W. Bush signed the Act into law on November 5, 2003, the plaintiffs filed this lawsuit claiming that the Act violates rights guaranteed by the U.S. Constitution. The City and County of San Francisco intervened as a plaintiff. On November 6, 2003, the district court issued a temporary injunction against enforcement of the Act.[9] At the government's request, the district court consolidated the preliminary injunction hearing and the trial on the merits. After an approximately three-week trial in which it heard the testimony of thirteen expert witnesses, the district court found the Act unconstitutional and entered a permanent injunction against its enforcement. *Planned Parenthood Fed'n of Am. v. Ashcroft*, 320 F. Supp. 2d 957, 1034-35 (N.D. Cal. 2004).

The district court's holding rested on its determination that the Act violated the Constitution in three respects. First, the district court found the Act unconstitutional because it imposed an undue burden on a

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[8] Congress also declared that courts must afford great deference to its findings, under the Supreme Court's holdings in *Turner Broadcasting System, Inc. v. FCC ("Turner II")*, 520 U.S. 180, 117 S. Ct. 1174, 137 L. Ed. 2d 369 (1997), and related cases. Partial-Birth Abortion Ban Act § 2(8)-(12). The level of deference that must be applied to Congress's findings is discussed *infra* in Section III.A.

[9] In two similar lawsuits, injunctions were also obtained from federal district courts in New York and Nebraska. *See Nat'l Abortion Fed'n ("NAF") v. Ashcroft*, 330 F. Supp. 2d 436, 442 (S.D.N.Y. 2004); *Carhart v. Ashcroft*, 287 F. Supp. 2d 1015, 1016 (D. Neb. 2003).

woman's right to choose to terminate her pregnancy before viability. The court concluded that the Act's definition of "partial-birth abortion" reached all D & E procedures as well as certain induction abortions. Because D & E and induction procedures comprise nearly all post-first trimester abortions, the district court concluded that the Act created a risk of criminal liability for virtually all abortions performed after the first trimester, which, the district court found, placed a substantial obstacle in the path of abortion-seekers. In the alternative, the court found that the Act created an undue burden even if construed to apply only to intact D & Es. It found that the failure to distinguish between previability and postviability abortions placed a substantial obstacle in the path of women who seek or require an intact D & E prior to viability, even under the unconvincing alternate construction of the statute.

Second, the district court found the Act unconstitutionally vague. The court reasoned that the term "partial-birth abortion" was not recognized in the medical community, and the phrases "living fetus," "deliberately and intentionally," and "overt act" failed to put physicians on notice as to what procedures would violate the statute. As a result, the district court found that the Act deprived physicians of fair notice and encouraged arbitrary enforcement. The district court held that the inclusion of scienter requirements did not remedy the vagueness.

Third, the district court found the Act unconstitutional because it failed to include a health exception. The court held that as a preliminary matter, it need not decide the highly disputed issue of the proper standard of deference applicable to Congress's findings because, even under the most deferential standard of review,

Congress's finding that the prohibited procedures were never medically necessary to preserve women's health was not entitled to controlling deference. Instead, the court, on the basis of the record before Congress at the time it passed the Act, the record before the district court and Supreme Court in *Stenberg*, and the record adduced by the parties in the present case, concluded that the Act's failure to include a health exception rendered it unconstitutional.

D. Other Federal Courts' Treatment of the Act

In addition to the district court, three other federal courts have reviewed the Act and each has held it unconstitutional. The Eighth Circuit declared the Act unconstitutional because it failed to contain an exception for women's health as required under *Stenberg*. *Carhart v. Gonzales*, 413 F.3d 791, 803-04 (8th Cir. 2005).[10] The district court in that case also found the Act unconstitutional because of the lack of a health exception, as well as because it imposed an undue burden on a woman's ability to choose a previability, post-first trimester abortion. *Carhart v. Ashcroft*, 331 F. Supp. 2d 805, 809 (D. Neb. 2004).[11] Finally, the District

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[10] Because it found the Act unconstitutional on the ground that it lacked a health exception, the Eighth Circuit declined to reach the statute's other potential constitutional infirmities. *Carhart*, 413 F.3d at 803-04.

[11] In addition, the Nebraska district court noted that the law would be unconstitutionally vague if the government's "'specific intent' construction" of the statute was not valid. Although the court accepted the government's construction, the judge stated, "I would not be surprised if I was reversed on this point. If I have erred by accepting [the government's] construction, and that is a close question, then the statute is obviously far too vague." *Carhart*, 331 F. Supp. 2d at 1040.

Court for the Southern District of New York found the Act unconstitutional because it did not contain a health exception. *Nat'l Abortion Fed'n. ("NAF") v. Ashcroft*, 330 F. Supp. 2d 436, 492-493 (S.D.N.Y. 2004).[12] None of these courts considered separately the question of remedy because under *Stenberg*, 530 U.S. at 946, 120 S. Ct. 2597, enjoining enforcement of the Act appeared to be mandatory at the time the decisions were issued. *Ayotte*, 126 S. Ct. at 969.

II. Standard of Review

We review an order granting a permanent injunction for abuse of discretion or application of erroneous legal principles, *Fortyune v. Am. Multi-Cinema, Inc.*, 364 F.3d 1075, 1079 (9th Cir. 2004), but review determinations underlying such a grant by the standard that applies-to such determinations. *Ting v. AT & T*, 319 F.3d 1126, 1134-35 (9th Cir. 2003). As a result, underlying legal rulings are reviewed *de novo* and underlying factual findings are reviewed under the clearly erroneous standard. *Id.* The question whether the Act imposes an undue burden or is unconstitutionally vague is a legal issue subject to *de novo* review. *Planned Parenthood of S. Ariz. v. Lawall ("Lawall II")*, 307 F.3d 783, 786 (9th Cir. 2002).

In analyzing a facial challenge to an abortion statute, we apply the undue burden standard established in *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 895, 112 S. Ct. 2791, 120 L. Ed. 2d 674 (1992). *Lawall II*, 307 F.3d at 786. "[T]he fact that the statute is susceptible to *some* constitutional application will not

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[12] The *NAF* court also declined to reach the other grounds for declaring the statute unconstitutional. *NAF*, 330 F. Supp. 2d at 482-83.

save it from facial attack. Rather, we must be satisfied that it will pose an undue burden in only a small fraction of relevant cases." *Planned Parenthood of Idaho Inc. v. Wasden*, 376 F.3d 908, 921 (9th Cir. 2004); *see also Richmond Med. Ctr. for Women v. Hicks*, 409 F.3d 619, 627-28 (4th Cir. 2005) (noting the recent Supreme Court case *Sabri v. United States*, 541 U.S. 600, 124 S. Ct. 1941, 158 L. Ed. 2d 891 (2004), makes clear that the "no set of circumstances" test for facial challenges from *United States v. Salerno*, 481 U.S. 739, 107 S. Ct. 2095, 95 L. Ed. 2d 697 (1987), "does not apply in the context of a facial challenge, like the one here, to a statute regulating a woman's access to abortion"). When the question concerns the existence of an adequate health exception, "facial challenges may prevail in an even broader group of cases: those where a law could preclude an abortion where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." *Wasden*, 376 F.3d at 921 n.10 (citing *Stenberg*, 530 U.S. at 930, 120 S. Ct. 2597) (internal quotation marks omitted); *see also Carhart*, 413 F.3d at 795 ("[I]f the Act fails the *Stenberg* test, it must be held facially unconstitutional."); *Women's Med. Prof'l Corp. v. Voinovich*, 130 F.3d 187, 196 (6th Cir.1997) ("[A] post-viability abortion regulation which threatens the life or health of even a few pregnant women should be deemed unconstitutional."), *quoted in Planned Parenthood of Rocky Mountains Serv. v. Owens*, 287 F.3d 910, 919 (10th Cir. 2002).

When determining the remedy for a statute found to be unconstitutional, we are guided by "three interrelated principles": one, we try to invalidate no more of a statute than is necessary to remedy the constitutional violation; two, we are mindful that the limited judicial

role and our institutional competence prevent us from rewriting a statute in order to make it constitutional; and three, any remedy we devise must be faithful to the legislative intent in enacting the statute. *Ayotte*, at 967-969.

III. Analysis

We hold that the Act is unconstitutional for three distinct reasons, each of which is sufficient to justify the district court's holding. First, the Act lacks the constitutionally required health exception. Second, it imposes an undue burden on women's ability to obtain previability abortions. Third, it is unconstitutionally vague, depriving physicians of fair notice of what it prohibits and encouraging arbitrary enforcement. For reasons explained in Section IV *infra*, we conclude that the appropriate remedy is to enjoin the enforcement of the Act. We therefore affirm the district court's issuance of the permanent injunction.

A. The Act Is Unconstitutional Because It Lacks Any Exception to Preserve the Health of the Mother

We hold that the omission of a health exception from the Act renders it unconstitutional. In reaching that conclusion, we first determine whether and in what circumstances a statute that regulates abortion but lacks a health exception is constitutional under *Stenberg*. Next, we consider the proper standard of review for the findings Congress made in support of its omission of a health exception from the Act. Finally, in light of this analysis, we assess the Act and the congressional findings that bear on its constitutionality.

i. The Standard for Evaluating Abortion Restrictions that Lack a Health Exception

Our analysis of whether the Act's lack of a health exception renders it unconstitutional is controlled by *Stenberg* and *Casey*. *Stenberg* reaffirms *Casey's* holding that the Constitution requires that any abortion regulation must contain such an exception if the use of the otherwise regulated procedure may in some instances be necessary to preserve a woman's life *or health*. *Wasden*, 376 F.3d at 922; *see also Hicks*, 409 F.3d at 625. *Stenberg* holds that an abortion regulation that fails to contain a health exception is unconstitutional except when there is a medical consensus that no circumstance exists in which the procedure would be necessary to preserve a woman's health. 530 U.S. at 937, 120 S. Ct. 2597. By medical consensus, we do not mean unanimity or that no single doctor disagrees, but rather that there is no significant disagreement within the medical community.

The *Stenberg* holding implements the health exception requirement announced in *Casey*. *Casey* held that even when the state's interest in regulating abortion is at its height (i.e., postviability), any restriction of an abortion method must include an exception when that method "'is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother'" in some circumstances. *Stenberg*, 530 U.S. at 921, 120 S. Ct. 2597 (quoting *Casey*, 505 U.S. at 879, 112 S. Ct. 2791 (quoting *Roe* v. *Wade*, 410 U.S. 113, 164-65, 93 S. Ct. 705, 35 L. Ed. 2d 147 (1973))). The Supreme Court noted that the phrase "necessary, in appropriate medical judgment" does not require "absolute necessity," "absolute proof," or "unanimity of medical opinion" regarding the need for the use of the regulated

procedure to preserve women's health in some instances. *Stenberg*, 530 U.S. at 937, 120 S. Ct. 2597. In fact, the Court emphasized that, for purposes of Casey's requirement that an abortion ban have a health exception, "division of medical opinion . . . signals the presence of risk, not its absence," and thus compels the inclusion of the exception in the statute. *Id.* Because "uncertainty" or division in the medical community regarding the need for a health exception "means a significant likelihood that those who believe that [a particular type of abortion procedure] is a safer abortion method in certain circumstances [than the alternatives] may turn out to be right," the Court held that as long as there is a lack of consensus in that community, any regulation of an abortion method must contain a health exception. *Id.* at 937-38, 120 S. Ct. 2597. Without a medical consensus, the Court stated, it is impossible for a legislative body to determine that "a health exception is never necessary to preserve the health of women" and, in such circumstance, any abortion regulation the legislature enacts without a health exception is unconstitutional. *Id.* (internal quotation marks omitted); *see also Carhart*, 413 F.3d at 796 ("[W]e believe when a lack of consensus exists in the medical community, the Constitution requires legislatures to err on the side of protecting women's health by including a health exception."). Under the constitutional rule established in *Stenberg*, therefore, we must inquire whether—applying the appropriate degree of deference to the legislative body's findings—the legislature properly concluded that there is *consensus in the medical community* that the banned procedure is never

medically necessary to preserve the health of women. *See NAF*, 330 F. Supp. 2d at 488.[13]

ii. Identifying and Applying the Appropriate Level of Deference to Congress's Factual Findings in the Act

Having identified the inquiry we must undertake in order to assess the constitutionality of the Act's lack of a health exception, we now turn to the level of deference we must apply to the relevant congressional findings. Here, Congress omitted a health exception because it found that "the facts indicate that a partial-birth abortion is never necessary to preserve the health of a woman," Partial-Birth Abortion Ban Act § 2(13), and that a "moral, medical and ethical consensus" exists that "partial-birth abortion" is "never medically necessary and should be prohibited." *Id.* at § 2(1). Under *Stenberg*, the former finding is dependent on the validity of the latter.

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[13] The government's argument that the lack of medical consensus was "only one of four 'evidentiary circumstances' bearing on the question of comparative safety" and not the "dispositive constitutional standard" misconstrues the *Stenberg* opinion. A careful reading of *Stenberg* makes clear that the Court discusses the "evidentiary circumstances" in the context of *Casey's* principle that an abortion restriction must contain a health exception when "necessary, in appropriate medical judgment, for the . . . health of the mother." As explained above, the requirement that a lack of medical consensus mandates the inclusion of a health exception is the direct manifestation of this principle. The "medically related evidentiary circumstances" are discussed by the Court in explaining its conclusion that there was a lack of medical consensus about the need for a health exception to the ban contained in the Nebraska statute and thus the statute was unconstitutional. The discussion of these "medically related evidentiary circumstances" does not establish or imply that "comparative safety," as determined by the legislative body, is the standard for assessing an abortion ban that lacks a health exception.

The government and many of the amici argue that Congress's findings of fact in this case should be evaluated under the standard articulated by the Court in *Turner Broadcasting System v. FCC* ("*Turner II*"), 520 U.S. 180, 117 S. Ct. 1174, 137 L. Ed. 2d 369 (1997), and related cases. Under this standard, when reviewing findings of fact that bear on the constitutionality of a statute, a reviewing court need only "'assure that, in formulating its judgments, Congress has drawn reasonable inferences based on substantial evidence.'" *Id.* at 195, 117 S. Ct. 1174 (quoting *Turner Broad. Sys. v. FCC* ("*Turner I*"), 512 U.S. 622, 666, 114 S. Ct. 2445, 129 L. Ed. 2d 497 (1994)). The Court has explained that when applying the substantial evidence standard, "the possibility of drawing two inconsistent conclusions from the evidence does not prevent . . . [a] finding from being supported by substantial evidence." *Turner II*, 520 U.S. at 211, 117 S. Ct. 1174 (internal quotation marks and citations omitted). The appellants and other amici, however, strongly argue that *Turner* does not apply to evaluations of the Act's constitutionality.

As an initial matter, we note that the Court's treatment of the level of deference to be applied to congressional findings that bear on the constitutionality of statutes has been less than clear. In some cases, the Court has expressly applied the substantial evidence standard described in *Turner* and related decisions. *See, e.g., McConnell v. FEC*, 540 U.S. 93, 165, 124 S. Ct. 619, 157 L. Ed. 2d 491 (2003). In others, the Court, without mentioning *Turner* or substantial evidence, and without identifying the standard of review it is applying, has reviewed congressional findings of fact with considerably less deference. *See, e.g., Bd. of Trustees of Univ. of Ala. v. Garrett*, 531 U.S. 356, 368-72, 121 S. Ct. 955, 148

L. Ed. 2d 866 (2001); *United States v. Morrison*, 529 U.S. 598, 609-13, 120 S. Ct. 1740, 146 L. Ed. 2d 658 (2000). Considered together, these cases make it difficult to identify the proper standard to be applied to congressional findings that bear on the constitutionality of certain statutes; in fact, they suggest that no single standard exists.

Fortunately, we need not resolve the question of the proper standard of review for findings made pursuant to the Act. Under even the most deferential level of review, the one identified as applicable in Congress's findings and by the government in its arguments to this court, we cannot defer to the critical congressional finding in this case: that there is a consensus in the medical community that the prohibited procedures are never necessary to preserve the health of women choosing to terminate their pregnancies. The record before Congress clearly demonstrates that no such consensus exists, as do the congressional findings themselves. As a result, we cannot uphold the finding to the contrary, even if we apply substantial evidence review.

Although Congress found that "[a] moral, medical, and ethical consensus exists that the practice of performing a partial-birth abortion . . . is never medically necessary," Partial-Birth Abortion Ban Act § 2(1), that finding is directly belied by another of Congress's findings and by the record that Congress developed in support of the legislation. The evidence of the lack of medical consensus is replete throughout that record and is confirmed in a significant statutory finding. As the district court pointed out, "Congress' [s]very findings contradict its assertion that there is a consensus. Congress subsequently noted in its findings that 'a prominent medical association,' the AMA, concluded

that '*there is no consensus* among obstetricians about' the use of intact D & E." *Planned Parenthood*, 320 F. Supp. 2d at 1025 (citing Partial-Birth Abortion Ban Act § 2(14)(C)) (emphasis added). The district court also noted that "Congress . . . had before it a joint statement from the AMA and ACOG, the two largest medical organizations taking positions on the issue, which recognized the disagreement among and within the two organizations." *Id.* at 1025. Furthermore, "nearly half (22 out of 46) of all individual physicians who expressed non-conclusory opinions to Congress" stated that the banned procedures were necessary in at least some circumstances, as did professors of obstetrics and gynecology from many of the nation's leading medical schools. *Carhart*, 331 F. Supp. 2d at 1009; *see also Planned Parenthood*, 320 F. Supp. 2d at 1025-26 (describing other evidence before Congress demonstrating a lack of medical consensus).

The evidence before Congress at the time it passed the Act, as well as other evidence presented during litigation, has led every court that has considered the statute's constitutionality to conclude that no medical consensus exists that the abortion procedures outlawed by the Act are never necessary to preserve the health of a woman—and we agree. *See Carhart*, 413 F.3d at 802 ("If one thing is clear from the record in this case, it is that no consensus exists in the medical community. The record is rife with disagreement on this point, just as in *Stenberg*."); *Carhart*, 331 F. Supp. 2d at 1008 ("In fact, there was no evident consensus in the record that Congress compiled. There was, however, a substantial body of medical opinion presented to Congress in opposition."); *id.* at 1009 ("Based upon its own record, it was unreasonable to find, as Congress did, that there

was 'consensus' of medical opinion supporting the ban. Indeed, a properly respectful review of that record shows that a substantial body of contrary, responsible medical opinion was presented to Congress. A reasonable person could not conclude otherwise."); *NAF*, 330 F. Supp. 2d at 482 ("There is no consensus that [intact D & E] is never medically necessary, but there is a significant body of medical opinion that holds the contrary."); *Planned Parenthood*, 320 F. Supp. 2d at 1025 ("[T]he evidence available to Congress in passing the Act in 2003, and currently before this court, very clearly demonstrates . . . that there is no medical or ethical consensus regarding either the humanity, necessity, or safety of the procedure.").

The government all but admits in its reply brief that no medical consensus exists regarding the need for the prohibited procedures to preserve the health of women in certain circumstances. *See* Appellant's Reply Brief at 25 (admitting that "both sides now concede the existence of 'contradictory evidence' in the congressional and trial records"). Nonetheless, it argues that the lack of consensus regarding whether the procedures prohibited by the Act are ever necessary to preserve the health of women is irrelevant because under *Turner* courts must resolve reasonable factual disagreements in favor of congressional findings. The flaw in the government's argument is not the standard of review it invokes, which may or may not be correct, but the factual dispute it identifies as relevant. In reviewing the Act's lack of a health exception, the dispositive question is not, as the government asserts, whether Congress's finding that the prohibited procedures are never necessary to preserve the health of a mother offers a reasonable (or plausible) resolution of a genuine

factual dispute (which incidentally the record shows it does not). Rather, under *Stenberg*, it is whether there is general agreement in the medical community that there are no circumstances in which the procedure would be necessary to preserve a woman's health.

Even the most cursory review of the Act and the congressional record developed in support of it reveals that no such medical consensus exists, a fact that the government essentially concedes in its brief to this court and that is fully confirmed by the evidence introduced in the district court during trial. Thus, whether we use *Turner's* substantial evidence test or a more rigorous standard, under no circumstances would the record permit us to uphold a finding that meets the *Stenberg* requirement of the absence of a division of opinion in the medical community.

We conclude that we cannot defer to Congress's finding that the procedures banned by the Act are never required to preserve the health of women; to the contrary, we are compelled to conclude, on the basis of the record before Congress, of the congressional findings themselves, and of evidence introduced in the district court, that a substantial disagreement exists in the medical community regarding whether those procedures are necessary in certain circumstances for that purpose. In such circumstance, we are compelled to hold that a health exception is constitutionally required. We therefore affirm the district court's holding that Congress's failure to include a health exception in the statute renders the Act unconstitutional.[14]

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[14] Our conclusion applies whether the Act is construed as banning only intact D & Es or all D & Es. *See* section III.B *infra*. Whenever a procedure is banned that may be necessary to

B. The Act is Unconstitutional Because It Imposes an Undue Burden on Women's Right to Choose a Previability Abortion

In addition to its lack of a health exception, the Act suffers from other major deficiencies that lead us to conclude that it is unconstitutional, including the undue burden it imposes on a woman's constitutional right to choose to have an abortion before the fetus is viable.[15] The Constitution guarantees a woman the right to choose to terminate a previability pregnancy. *Stenberg*, 530 U.S. at 921, 120 S. Ct. 2597 (quoting *Casey*, 505 U.S. at 870, 112 S. Ct. 2791); *Tucson Woman's Clinic v. Eden*, 379 F.3d 531, 539 (9th Cir. 2004) (as amended); *Wasden*, 376 F.3d at 921. Although the Constitution firmly guarantees women that right, the state may seek to protect its interest in fetal life by regulating the means by which abortions may be secured, provided the regulations do not impose an "undue burden" on a woman's ability to obtain an abortion. *Stenberg*, 530 U.S. at 921, 120 S. Ct. 2597; *Casey*, 505 U.S. at 874, 112 S. Ct. 2791; *see also Tucson Woman's Clinic*, 379 F.3d at 539; *Wasden*, 376 F.3d at 921. An "'undue burden is . . . shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial

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preserve *some* women's health, a statutory exception is required. *Stenberg*, 530 U.S. at 934-38, 120 S. Ct. 2597.

[15] The question of the constitutionality of statutes that regulate "partial-birth abortions" is of substantial importance and requires as prompt an answer as possible. Rather than relying solely on one ground and reserving the other questions as to the statute's constitutionality for later adjudication, we deem it best to decide simultaneously all constitutional issues raised. Moreover, whether a remedy other than enjoining enforcement of the Act in its entirety is appropriate may depend in part on the nature and extent of the constitutional violations. *See Ayotte*, at 968.

obstacle in the path of a woman seeking an abortion of a nonviable fetus.'" *Stenberg*, 530 U.S. at 921, 120 S. Ct. 2597 (quoting *Casey*, 505 U.S. at 877, 112 S. Ct. 2791).

In *Stenberg*, the Court held that a Nebraska statute regulating so-called "partial-birth abortions" imposed an undue burden. Without deciding the issue whether a statute that outlawed only intact D & Es would be unduly burdensome, the *Stenberg* court held that an abortion ban that failed to differentiate in its statutory language between intact D & Es and non-intact D & Es unquestionably constituted an undue burden, for the obvious reason that it would prohibit most second trimester abortions. *Stenberg*, 530 U.S. at 938-46, 120 S. Ct. 2597. As part of its analysis, the *Stenberg* Court provided legislatures with guidance about how to draft statutes that would adequately distinguish between the two forms of D & E. The Court explained that a legislature can make clear that a statute intended to regulate only intact D & Es applies to that form of the procedure only, by using language that "track[s] the medical differences between" intact and non-intact D & Es or by providing an express exception for the performance of non-intact D & Es and other abortion procedures. *Stenberg*, 530 U.S. at 939, 120 S. Ct. 2597.[16]

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[16] As an example, the Court cited Kansas's "partial-birth abortion" ban which explicitly exempts the "dilation and evacuation abortion procedure involving dismemberment of the fetus prior to removal from the body of the pregnant woman." Kan. Stat. Ann. § 65-6721(b)(2) (Supp. 1999), *cited in Stenberg*, 530 U.S. at 939, 120 S. Ct. 2597. The Ohio "partial-birth abortion" ban recently upheld by the Sixth Circuit also specifically exempts non-intact D & Es in its statutory language. *See Women's Med. Prof'l Corp. v. Taft*, 353 F.3d 436, 452 (6th Cir. 2003) (upholding Ohio Rev. Code Ann. § 2919.151 (Anderson 2002)); *see also Planned Parenthood of Cent. N.J. v. Farmer*, 220 F.3d 127, 140 (3rd Cir. 2000) (declaring New

In her concurring opinion, Justice O'Connor emphasized how by employing the latter approach, a legislature could easily make clear that a statute intended to regulate intact D & E was in fact narrowly tailored to reach only that form of the D & E procedure. *Stenberg*, 530 U.S. at 950, 120 S. Ct. 2597 (O'Connor, J., concurring). Citing three state statutes prohibiting intact D & Es which had "specifically exclud[ed] from their coverage" other abortion methods,[17] Justice O'Connor described the language each statute used, providing legislatures wishing to prohibit only intact D & Es with a clear roadmap for how to avoid the problems regarding the scope of coverage that undid the Nebraska statute. *Id.*

When drafting the Act, however, Congress deliberately chose not to follow the Court's guidance. *See* Section IV *infra*. The Act's definition of the prohibited procedures does not attempt to track the medical differences between intact D & E and other forms of D & E, nor does it explicitly exclude non-intact D & Es from its reach. Instead of using either of these approaches for accomplishing the objective the government embraces in its brief—prohibiting only intact D & Es, Congress defined the prohibited procedure in a way that a number of doctors have explained includes both intact and non-intact D & Es, and that we likewise

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Jersey's "partial-birth abortion" ban unconstitutional and stating that "[i]f the Legislature intended to ban only the [intact D & E] procedure, it could easily have manifested that intent either by specifically naming that procedure or by setting forth the medical definition of [intact D & E] utilized by the ACOG").

[17] In addition to the Kansas statute referenced in the majority opinion, Justice O'Connor also cited laws enacted by Montana, Mont. Code Ann. § 50-20-401(3)(c)(ii) (Supp. 1999), and Utah, Utah Code Ann. § 76-7-310.5(1)(a) (1999). *Stenberg*, 530 U.S. at 950, 120 S. Ct. 2597 (O'Connor, J., concurring).

conclude bans both forms of the procedure. Because the Act, like the statute invalided in *Stenberg*, would allow prosecutors to pursue physicians who "use [non-intact] D & E procedures, the most commonly used method for performing previability second trimester abortions" and would cause all doctors performing those procedures to "fear prosecution, conviction, and imprisonment," *Stenberg*, 530 U.S. at 945, 120 S. Ct. 2597, it too is unconstitutional.[18] Neither the differences the government cites between the language of the Act and the Nebraska statute nor the scienter requirements contained in the Act limit its application to the intact D & E procedure and neither, therefore, serves to cure the statute's constitutional infirmity.

i. The Act Encompasses Non-Intact D & E Procedures

The government offers no explanation for why Congress did not adopt either of the two approaches outlined by the Court and Justice O'Connor in *Stenberg* for legislating a prohibition that is applicable only to the intact D & E procedure. Rather, it asserts that the federal statute differs from the Nebraska statute invalidated in *Stenberg* in three significant respects that collectively make it clear that the Act applies only to that form of the procedure. It argues that, as a result, the Act is constitutional although the Nebraska law was not. The differences in statutory language to which the government points fall far short, however, of ade-

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[18] *Stenberg* held that a regulation that prohibits non-intact D & Es as well as intact D & Es imposes an undue burden. *Stenberg*, 530 U.S. at 938, 120 S. Ct. 2597. Because the prohibition here applies to both, we need not reach the issue whether the Act also applies to induction procedures. Nor need we decide whether if the Act applied only to intact D & Es, it would on that basis alone unduly burden the rights of women.

quately differentiating between the two forms of D & E, much less of achieving the degree of certainty regarding the Act's scope that Congress could have easily accomplished had it followed *Stenberg*, either by tracking the medical differences between intact D & E and other forms of D & E or by specifying that the forms of D & E other than the intact version are not covered by the prohibition.

The three differences between the Act and the Nebraska statute that the government relies on are as follows. First, the government notes that unlike the Nebraska statute which applied when the living fetus or a substantial portion of it was delivered "into the vagina," Neb. Rev. Stat. § 28-326(9), the federal Act applies only when there is a vaginal delivery "outside the body of the mother," 18 U.S.C. § 1531(b)(1)(A). The government argues that because non-intact D & E generally involves dismemberment of the fetus before it leaves the mother's body, the specification that the Act applies only when a living fetus or a part thereof is delivered outside the mother's body makes clear that the Act does not apply to that procedure. The government's claim is incorrect. As the record demonstrates and the district court found, in non-intact D & Es, a doctor may extract a substantial portion of the fetus—including either a part of the fetal trunk past the navel or the entire fetal head—to the point where it is outside the body of the mother before the fetal disarticulation occurs. Although different from the provision in the Nebraska statute, the "outside the body of the mother" provision does not limit the Act's reach to intact D & Es and, as a result, does not eliminate the undue burden the Act imposes.

Second, the Nebraska statute applied only when "a living unborn child, or a substantial portion thereof" is delivered for the purpose of performing a prohibited act, Neb. Rev. Stat. § 28-326(9), whereas the federal Act states its prohibition applies only when either the "entire fetal head" or "any part of the fetal trunk past the navel" of a living fetus is delivered for a similar purpose, 18 U.S.C. § 1531(b)(1)(A). The government argues that the use of a "specific anatomic landmark" addresses the concern the Supreme Court expressed with the "substantial portion" language of the Nebraska statute.[19] As with the first difference relied upon by the government, however, the "specific anatomic landmark" language makes the Act different from the Nebraska statute but does not exclude non-intact D & Es from the Act's coverage. As the district court found, intact D & Es are not the only form of D & E in which the "entire fetal head" or "any part of the fetal trunk past the navel" of a living fetus may be delivered prior to the performance of an act banned by the statute: the "anatomic landmark" specified in the Act may be reached by doctors performing either intact or non-intact D & Es.[20] Accordingly, this second differ-

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[19] In *Stenberg*, the Court stated it did not understand how using the language of the Nebraska statute "one could distinguish . . . between [non-intact] D & E (where a foot or arm is drawn through the cervix) and [intact D & E] (where the body up to the head is drawn through the cervix). Evidence before the trial court makes clear that [non-intact] D & E will often involve a physician pulling a 'substantial portion' of a still living fetus, say, an arm or leg, into the vagina prior to the death of the fetus." 530 U.S. at 939, 120 S. Ct. 2597.

[20] In a non-intact D & E, the presence of "some part of the fetal trunk past the navel . . . outside the body of the mother" can occur, for instance, when "on an initial pass into the uterus with

ence from the Nebraska statute, like the first, does not establish that the Act is applicable only to intact D & Es.

Third, the Nebraska statute applied when a doctor "deliberately and intentionally deliver[s] into the vagina a living unborn child, or a substantial portion thereof, *for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child.*" Neb. Rev. Stat. § 28-326(9) (emphasis added). The federal statute, however, requires that a doctor "deliberately and intentionally vaginally deliver[ ] a living fetus . . . *for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus*" and "*perform [ ] the overt act, other than completion of delivery, that kills the partially delivered living fetus.*" 18 U.S.C. § 1531(b)(1)(A), (B). The government argues that this "overt act" requirement unambiguously establishes that the Act does not apply to abortion procedures other than intact D & Es. However, this language is also not as restrictive as the government claims. In non-intact D & Es, as well as in the intact form of the procedure, if the fetus has been brought to either of the two anatomic landmarks specified in the Act, a doctor may then, in order to complete the abortion safely, need to perform an "overt act," other than

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forceps, the physician disarticulates a small fetal part, which does not cause immediate demise, and then on a subsequent pass, the fetus is brought out of the cervix past the fetal navel" before further disarticulation occurs or when "on an initial pass into the uterus with forceps, the physician brings out a fetal part—either attached to the rest of the fetus, or not—that is 'part of the fetal trunk past the navel,' but the extraction does not cause immediate demise." *See Planned Parenthood*, 320 F. Supp. 2d at 972.

completing delivery, that the physician knows the fetus cannot survive, if it is still living, and that "kills" the fetus. The "overt act" that may be performed in a non-intact D & E includes disarticulating the fetus or compressing the abdomen or other fetal part that is obstructing the completion of the uterine evacuation. As with the other two differences in the statutory language that the government claims clearly establish that the Act applies only to intact D & E, the "overt act" language does not so restrict the Act's applicability.

Contrary to the government's claim, properly construed the Act covers non-intact as well as intact D & Es. As a result, despite containing some provisions that are different in form from those in the Nebraska statute, the Act is sufficiently broad to cause those who perform non-intact D & E procedures to "fear prosecution, conviction, and imprisonment." *Stenberg*, 530 U.S. at 945, 120 S. Ct. 2597. The resulting chilling effect on doctors' willingness to perform previability post-first trimester abortions would impose an undue burden on the constitutional rights of women. *Id.*[21]

ii. The Act's Scienter Requirements Do Not Cure the Constitutional Infirmity

The government also argues that the Act's scienter requirements preclude application of the statute to physicians who perform non-intact D & E procedures and that the federal statute should therefore survive constitutional scrutiny. Although the Act does limit its reach to those who "*knowingly* perform a partial-birth

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[21] We note that the Act's reference to "living fetus" does not differentiate it from the Nebraska statute, which used the same term. Nor does this or any other language in the Act limit its applicability to viable fetuses. *See infra* pages 38a-39a.

abortion," 18 U.S.C. § 1531(a) (emphasis added), and "*deliberately and intentionally* vaginally deliver[] a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother," 18 U.S.C. § 1531(b)(1)(A) (emphasis added), these scienter requirements do not permit us to interpret the Act as reaching only the intact D & E procedure.

The government's argument about the restrictive effect of the statute's scienter requirements depends on the premise that, once the scienter requirements are applied, the Act's description of the prohibited procedure includes only intact D & Es. However, that is simply not the case. The actions described in the statute's definition of the prohibited procedure can be performed with the requisite intent in both the intact and the non-intact forms of the D & E procedure. For instance, the record shows that a doctor performing a non-intact D & E of a fetus in the breech position may, in order to minimize the number of disarticulated fetal parts removed from the woman's body, "deliberately and intentionally vaginally deliver[] a living fetus until . . . the fetal trunk past the navel is outside the body of the mother" before performing the acts of disarticulation. Such an abortion meets all of the requirements of the procedure outlawed by the Act—the doctor knowingly, deliberately, and intentionally vaginally delivers the fetus to the specific anatomic landmark and does so for the purpose of performing an "overt act [the disarticulation] that [he] knows will kill the partially delivered living fetus" and performs that act. *See, e.g.*, Brief of Amici Curiae the California Medical Associa-

tion et al. at 22.[22] Even with the Act's scienter requirements, therefore, non-intact D & Es readily fall within the scope of the statute's description of the banned procedure. As a result, the inclusion of the scienter requirements does not resolve the undue burden concerns recognized by the Supreme Court in *Stenberg*.

iii. Conclusion

The Act's definition of the prohibited procedure, like that of the unconstitutional Nebraska statute, covers both forms of D & E, intact and non-intact. In any event, it fails to differentiate between the two sufficiently clearly to permit doctors to perform the latter procedure without fear of prosecution. Because the Act applies to, or could readily be employed to prosecute, physicians who "use [non-intact] D & E procedures, the most commonly used method for performing previability second trimester abortions," *Stenberg*, 530 U.S. at 945, 120 S. Ct. 2597, it imposes a substantial risk of criminal liability on almost all doctors who perform previability abortions after the first trimester. Thus, the Act would, at a minimum, create a chilling effect that "'plac[es] a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.'" *Id.* at 921, 120 S. Ct. 2597.[23] We conclude that, because of

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[22] Because the Act's definition reaches many non-intact D & E procedures even if "deliberately and intentionally" modifies not only the vaginal delivery language but also the language describing the other steps contained in the Act's definition of "partial-birth abortion," it is unnecessary to resolve the parties' dispute as to which parts of the procedure as defined by the Act the "deliberately and intentionally" requirement applies.

[23] We do not reach the question whether the Act would impose an undue burden if it clearly applied only to intact D & Es,

both the actual and the potential risk to doctors who perform previability abortions, the Act imposes an "undue burden upon a woman's right to make an abortion decision," *id.* at 946, 120 S. Ct. 2597, and is unconstitutional.

C. The Act is Unconstitutionally Vague

Besides lacking the required health exception and imposing an undue burden on a woman's right to terminate her pregnancy, the Act is also unconstitutionally vague. It fails to define clearly the medical procedures it prohibits, depriving doctors of fair notice and encouraging arbitrary enforcement. The Act's scienter requirements do not cure the statute's vagueness. We conclude that the Act's unconstitutional vagueness constitutes an independent ground for affirming the district court's finding of unconstitutionality.

To survive vagueness review, a statute must "(1) define the offense with sufficient definiteness that ordinary people can understand what conduct is prohibited; and (2) establish standards to permit police to enforce the law in a non-arbitrary, non-discriminatory manner." *Nunez by Nunez v. City of San Diego*, 114 F.3d 935, 940 (9th Cir. 1997) (citing *Kolender v. Lawson*, 461 U.S. 352, 357, 103 S. Ct. 1855, 75 L. Ed. 2d 903 (1983)). The need to avoid vagueness is particularly acute when the statute imposes criminal penalties, *see Forbes v. Napolitano*, 236 F.3d 1009, 1011-12 (9th Cir. 2000) (as amended), or when it implicates constitutionally protected rights, *see Nunez by Nunez*, 114 F.3d at 940. Because this statute both imposes criminal penalties and implicates a constitutionally protected right, it is

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although the question presents at the least a substantial constitutional issue.

subject to heightened vagueness review. *Id.* The Act cannot survive that review.

The government essentially makes three arguments regarding the vagueness of the Act. First, it asserts that the statutory scheme as a whole "specifically and narrowly defines" the single "method of abortion" that it outlaws (i.e., intact D & E). As we have explained, *Stenberg* explicitly described, for the benefit of legislative bodies (and, presumably, the government), two possible ways to make clear that a prohibition on intact D & E is applicable only to that form of the procedure. Congress deliberately declined to adopt either method and instead drafted statutory language that may best be understood as also outlawing non-intact D & Es, the type of procedure most often used to perform post-first trimester previability abortions. This reading of the statute was confirmed by the trial testimony of numerous doctors and practitioners offering abortion services. As the district court noted, "they do not understand exactly what the Act prohibits." *Planned Parenthood*, 320 F. Supp. 2d at 977.[24] Although we may conclude following a painstaking legal analysis that the statute covers both forms of D & E, the language of the statute, taken as a whole, is not sufficiently clear regarding what it permits and prohibits to guide the conduct of

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[24] In citing the testimony of the doctors who testified at trial, the district court was not treating its vagueness determination as an "evidentiary question," as the government claims. Rather, it used that testimony to help it understand the steps involved in the different forms of D & E and induction, in order to assess whether the Act's language was sufficiently clear, and, in the district judge's own words, to "confirm[]" its legal conclusion that the Act was vague. *Planned Parenthood*, 320 F. Supp. 2d at 977. This is an entirely appropriate use of expert testimony by a court as part of a vagueness inquiry.

those affected by its terms, specifically medical practitioners. As a result, the Act is unconstitutionally vague, and certainly so if the legislative intent was, as the government argues, to restrict its scope to intact D & E.

Second, the government objects to the district court's conclusion that the specific terms "partial-birth abortion," "overt act," and "living fetus" are "fatally ambiguous." As to the term "partial-birth abortion," the government challenges the district court's statement that the term has "little if any medical significance," arguing that it is "'widely known' as synonymous with the medical terms 'D & X' and 'intact D & E.'" The only citation the government offers to support this argument is a Sixth Circuit case, *Women's Med. Prof'l Corp. v. Taft*, 353 F.3d 436, 439-40 (6th Cir. 2003), which considered an Ohio ban on "partial-birth abortion." *Taft*, however, does nothing to bolster the government's argument that the term "partial-birth abortion" is, in and of itself, sufficiently clear as to the procedures it encompasses that any vagueness problems with the statute are cured. In fact, the contrast between the Ohio statute reviewed in *Taft* and the federal Act at issue here illuminates the latter's vagueness. In *Taft*, the Sixth Circuit's conclusion that the Ohio statute survived vagueness review did not rest at all on the proposition that the term "partial-birth abortion" is "'widely known' as synonymous with the medical terms 'D & X' and 'intact D & E.'" Rather, the Sixth Circuit held the Ohio law was not unconstitutionally vague because the statute defined the restricted procedures using "clinical terms" and explicitly stated that it did not apply to non-intact D & E or other abortion proce-

dures besides intact D & E.[25] *Taft*, 353 F.3d at 441. The Sixth Circuit noted that by defining the reach of its statute's prohibition in this way, Ohio heeded the Supreme Court's observation in *Stenberg* that "Nebraska might have fared better if its description of the procedure had 'tracked the medical differences between [non-intact] D & E and [intact D & E],' [or] 'provided an exception for the performance of [non-intact] D & E and other abortion procedures.'" *Taft*, 353 F.3d at 452 (quoting *Stenberg*, 530 U.S. at 939, 120 S. Ct. 2597). By contrast, Congress chose to ignore *Stenberg's* warning when it enacted the Act, as noted in the previous section, and failed to follow its clear roadmap—either by defining the scope of the statute's prohibition using clinical terms that track the medical differences between intact D & E and other forms of D & E or by delineating expressly which procedures are exempted from the ban. The *Taft* decision, therefore, provides no support for the proposition that the term "partial-birth abortion" is concrete enough on its own to obviate any vagueness concerns with a statute that seeks to outlaw it. The government cites no other case, in this circuit or any other, that supports its proposition and thus has offered no justification for its claim that "partial-birth abortion," which is not a recognized medical term, is itself sufficiently clear to overcome the vagueness concerns identified by the district court.

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[25] As the *Taft* court reported, one provision of the Ohio statute provided, "This section does not prohibit the suction curettage procedure of abortion, the suction aspiration procedure of abortion, or the dilation and evacuation procedure of abortion." 353 F.3d at 452. Another part of the Ohio statute further clarifies the scope of its prohibition, stating "'[d]ilation and evacuation procedure of abortion' does not include the dilation and extraction procedure of abortion." *Id.*

Alternatively, the government argues that "partial-birth abortion" is an "expressly defined term [in the statute] . . . and thus cannot itself support a vagueness challenge." However, the mere fact that "partial-birth abortion" is an "expressly defined term" in the statute is not enough to survive vagueness review if that definition is itself vague, as is the case here. *See, e.g., Planned Parenthood of Cent. N.J. v. Farmer*, 220 F.3d 127, 136-40 (3d Cir. 2000) (finding a New Jersey statute outlawing "partial-birth abortion" unconstitutional based on its conclusion that its definition of "partial-birth abortion" was vague). Although the federal Act uses somewhat different language from that used in the statute invalidated in *Stenberg*, its definition of "partial-birth abortion" nonetheless "fails to provide a reasonable opportunity to know what conduct is prohibited" and "is so indefinite as to allow arbitrary and discriminatory enforcement." *Tucson Woman's Clinic*, 379 F.3d at 554. The Act does not "specifically and narrowly define[]" a single "method of abortion," as the government claims; rather, its provisions could readily be applied to a range of methods of performing post-first trimester abortions. Furthermore, as discussed above, Congress chose not to take the simple steps, suggested by the Court in *Stenberg*, to cure the vagueness in its definition of partial-birth abortion. As a result, doctors who perform non-intact D & E abortions, which the government contends are not intended to be outlawed by the Act, have good reason to fear that they will be deemed subject to its prohibitions. At the least, they cannot be reasonably certain that their conduct is beyond the reach of the Act's criminal provisions; nor can they be reasonably assured that the Act will not be arbitrarily enforced.

The government also objects to the district court's characterization of "overt act" as vague. It asserts that the term itself is not unconstitutionally vague, citing its use in the Constitution and various federal statutes. It further claims that by modifying "overt act" with the phrase "other than completion of delivery," the statute makes clear that the term does not apply to "cutting the umbilical cord" or other "essential aspects of delivery," which, it argues, establishes that the statute's ban does not encompass induction. While the government rightly points out that the term "overt act" is not in all usages unconstitutionally vague, the district court was correct to hold that in the context of the Act it is, even when modified by "other than completion of delivery." Beyond conclusory statements, the government in no way refutes the district court's determination that "overt act, other than completion of delivery" can plausibly encompass a range of acts involved in non-intact D & E, including disarticulation and compressing or decompressing the skull or abdomen or other fetal part that is obstructing completion of the uterine evacuation (and in induction, possibly even the cutting of the umbilical cord). Because these acts can readily be deemed covered by the phrase "overt act, other than completion of delivery," the phrase does not provide the definiteness about the statute's scope that the government asserts. The use of the term "overt act" does nothing to remedy the statute's failure to provide adequate notice of what forms of D & E the Act prohibits and to prevent its arbitrary enforcement. *See Forbes*, 236 F.3d at 1011.

The government additionally challenges the district court's conclusion that the term "living fetus" contributes to the vagueness of the statute. We, like the Third

Circuit, conclude that the use of "living fetus" in a statute banning "partial-birth abortions" adds to confusion about the scope of the prohibited conduct. Although the term "living fetus" may suggest to some that the Act's prohibition is limited to abortions of viable fetuses, the term has no such meaning. While a fetus typically is not viable until at least 24 weeks lmp, it can be "living"—meaning that it has a detectable heartbeat or pulsating umbilical cord—as early as seven weeks lmp, well before the end of even the first trimester. As the Third Circuit noted, "because a fetus may be 'living' as early as seven weeks lmp, use of the term 'living' instead of 'viable' indicates that, contrary to the understanding of a large segment of the public and the concomitant rhetoric, the Act is in no way limited to late-term, or even mid-term, abortions. . . . [M]ost common abortion procedures will fall within this limitation." *Farmer*, 220 F.3d at 137. Therefore, far from curing the statute's vagueness problems, the use of the term "living fetus" instead of "viable fetus" creates additional confusion about the Act's scope.

Third, the government argues that any unconstitutional vagueness is eliminated by the "narrowing and mutually reinforcing scienter requirements." However, as we explained in the undue burden section, section III.B *supra*, the scienter requirements do not restrict the statute's reach to doctors who purposely set out to perform the intact form of the D & E procedure. They therefore do not remedy the Act's failure to provide fair warning of the prohibited conduct; rather, they permit the Act's arbitrary and discriminatory enforcement. In short, as we recently held, a scienter requirement applied to an element that is itself vague does not cure the provision's overall vagueness. *See Wasden*, 376 F.3d at

933; *see also Farmer*, 220 F.3d at 138 ("At a minimum, to limit the scope of a statute to 'deliberately and intentionally' performing a certain procedure, the procedure itself must be identified or readily susceptible of identification. Here, it is not." (citations omitted)); *Planned Parenthood of Greater Iowa, Inc. v. Miller*, 195 F.3d 386, 389 (8th Cir. 1999) (holding that Iowa partial-birth abortion ban's inclusion of scienter requirement "cannot save it" because the Act still "encompasses more than just the [intact D & E] procedure"); *R.I. Med. Soc'y v. Whitehouse*, 66 F. Supp. 2d 288, 311-12 (D.R.I. 1999) (holding that scienter requirement could not save Rhode Island's partial birth abortion statute because the "scienter requirement modifies a vague term"). The scienter requirements, therefore, do nothing to cure the Act's vagueness.

Because neither the statute when read as a whole nor its individual components provide fair warning of the prohibited conduct to those it regulates and because the Act permits arbitrary and discriminatory enforcement, we affirm the district court's determination that the Act is unconstitutionally vague.

IV. Remedy

In considering the remedy for a statute found to restrict access to abortion in violation of the Constitution, we are guided by "[t]hree interrelated principles." *Ayotte*, at 967. First, we endeavor to invalidate no more of a statute than necessary. *Id.* Second, "mindful that our constitutional mandate and institutional competence are limited, we restrain ourselves from 'rewrit[ing] state law to conform it to constitutional requirements' even as we strive to salvage it." *Id.* (quoting *Virginia v. Am. Booksellers Ass'n*, 484 U.S. 383, 397, 108 S. Ct. 636, 98 L. Ed. 2d 782 (1988)). Third, in

devising the remedy we must be cognizant of legislative intent "for a court cannot 'use its remedial powers to circumvent the intent of the legislature.'" *Ayotte*, at 967 (quoting *Califano v. Westcott*, 443 U.S. 76, 94, 99 S. Ct. 2655, 61 L. Ed. 2d 382 (1979) (Powell, J., concurring in part and dissenting in part)). Applying these principles to the present case, we conclude that upholding the permanent injunction against the enforcement of the statute in its entirety is the only permissible remedy. We cannot, consistent with the judiciary's limited role, devise a narrower injunction that adequately addresses the various constitutional infirmities in the Act.

Our conclusion is dictated in part by the grounds on which we hold the Act unconstitutional. We do not conclude that it is unconstitutional solely due to its lack of a health exception. *Cf. Ayotte*, at 965 ("We granted certiorari to decide whether the courts below erred in invalidating the Act in its entirety because it lacks an exception for the preservation of pregnant minors' health." (internal citation omitted)). Had our holding on the statute's constitutionality rested solely on that ground, we might have been able to draft a more "finely drawn" injunction, *Ayotte*, at 969, prohibiting the Act's enforcement only when the banned procedure was necessary to preserve a woman's health. Because such relief would not require us to rewrite substantial portions of the statute, drafting the injunction would be within our institutional competence. Nonetheless, in the case of the Partial-Birth Abortion Ban Act, the issuance of such an order would not be consistent with the *Ayotte* precepts, because in order to do so we would be required to violate the intent of the legislature and usurp the policy-making authority of Congress.

Congress did not inadvertently omit a health exception from the Act. It was not only fully aware of *Stenberg's* holding that a statute regulating "partial-birth abortion" requires a health exception, but it adopted the Act in a deliberate effort to persuade the Court to reverse that part of its decision.[26] Congress was advised repeatedly that if it passed an abortion ban without a health exception, the statute would be declared unconstitutional,[27] yet it rejected a number of amend-

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[26] Senator Santorum, the lead sponsor of the Act in the Senate, stated during the floor debate, "We are here because the Supreme Court defended the indefensible [in *Stenberg*]. . . . We have responded to the Supreme Court. I hope the Justices read this Record because I am talking to you. . . . [T]here is no reason for a health exception." 149 CONG. REC. S3486 (daily ed. Mar. 11, 2003) (statement of Sen. Santorum); *see also* 149 CONG. REC. H4933 (daily ed. June 4, 2003) (statement of Rep. Conyers) ("[The Act] does not add a health exception but instead simply states that the procedures covered by the bill are not necessary and that their probation poses no risk to the mother's health. This declaration goes directly against the ruling of the Supreme Court in *Stenberg*. . . . The 'findings,' in effect, are an attempt to overturn *Stenberg*.").

[27] Numerous members of Congress stated during the debate on the Act that the statute was unconstitutional because it did not include a health exception. Senator Feinstein, for instance, said, "What is wrong with [the Act]? . . . To begin with, it is unconstitutional because it lacks a health exception. . . . A review of the Supreme Court's abortion decisions and the record makes clear that any ban on . . . what supporters of the Santorum bill incorrectly call partial-birth abortion—must include a health exception." 149 CONG. REC. S3601 (daily ed. Mar. 12, 2003) (statement of Sen. Feinstein). Arguing in favor an amendment he proposed, Senator Durbin stated one reason to support it was "because it has a health exception not contained in [the Act], it is more likely to withstand the constitutional challenge and scrutiny across the street at the Supreme Court." 149 CONG. REC. S3481 (daily ed. Mar. 11, 2003) (statement of Sen. Durbin). *See also, e.g.*, 149 CONG.

ments that would have added such an exception.[28] It considered the omission of the exception to be a critical

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REC. S3424 (daily ed. Mar. 11, 2003) (statement of Sen. Murray) ("[T]he Supreme Court found the State law unconstitutional [in *Stenberg*] because it did not contain an exception to protect the woman's health. . . . Guess what. The [Act] fails the same constitutional test."); 149 CONG. REC. S3576 (daily ed. Mar. 12, 2003) (statement of Sen. Mikulski) ("We are not loophole shopping when we insist that an exception be made in the case of serious and debilitating threats to a woman's physical health. This is what the Constitution requires. . . ."); 149 CONG. REC. S3561 (daily ed. Mar. 12, 2003) (statement of Sen. Boxer) ("We have a bill that, if it passes, makes no exception for the health of the mother. We have a bill that legal experts say is legally identical to the law that was ruled unconstitutional by the Supreme Court."); 149 CONG. REC. H4926 (daily ed. June 4, 2003) (statement of Rep. Nadler) ("The bill lacks an exception for the health of the woman. I know that some of my colleagues do not like the constitutional rule that has been in place and reaffirmed by the Court for 30 years; but that is the supreme law of the land, and no amount of rhetoric, even if written into legislation, will change that."); 149 CONG. REC. H4924 (daily ed. June 4, 2003) (statement of Rep. Green) ("[In *Stenberg*,] the Court ruled that any ban on methods of abortion must provide an exception for women's health, and also struck down the Nebraska law for failing to include such an exception. [The Act] continues to flout the Supreme Court's rulings. . . ."); 149 CONG. REC. S3611 (daily ed. Mar. 12, 2003) (statement of Sen. Jeffords); 149 CONG. REC. S3604 (daily ed. Mar. 12, 2003) (statement of Sen. Lautenberg); 149 CONG. REC. S3584 (daily ed. Mar. 12, 2003) (statement of Sen. Kennedy); 149 CONG. REC. S3599 (daily ed. Mar. 12, 2003) (statement of Sen. Cantwell); 149 CONG. REC. H4933 (daily ed. June 4, 2003) (statement of Rep. Farr); 149 CONG. REC. H4932 (daily ed. June 4, 2003) (statement of Rep. Filner); 149 CONG. REC. H4927 (daily ed. June 4, 2003) (statement of Rep. Larson); 149 CONG. REC. H4927 (daily ed. June 4, 2003) (statement of Rep. Lowey).

[28] The House Judiciary Committee rejected an amendment that would have added a health exception to the Act. H.R. REP. No. 108-58, at 71-73. In addition, the House itself rejected an

component of the legislation it was enacting. Both of the Act's main sponsors, as well as various co-sponsors, asserted that the purpose of the Act would be wholly undermined if it contained a health exception and that, if an exception were included, the statute would be of little force or effect.[29] Enacting a "partial-birth

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amendment that would have revised the ban by adding a health exception, among other changes. *See* 149 CONG. REC. H4948 (daily ed. June 4, 2003) (rejecting House Amendment 154). The House also rejected a motion to recommit the Act to the House Judiciary Committee with instructions to add a health exception. *See* 149 CONG. REC. H4949 (daily ed. June 4, 2003) (rejecting motion). The Senate rejected two amendments that would have revised the ban by adding a health exception, among other changes. *See* 149 CONG. REC. S3611 (daily ed. Mar. 12, 2003) (rejecting Senate Amendment 261); 149 CONG. REC. S3579 (daily ed. Mar. 12, 2003) (rejecting Senate Amendment 259). The Senate also rejected a motion to commit the Act to the Judiciary Committee with instructions to consider the constitutional issues raised in *Stenberg*, including those relating to a health exception. *See* 149 CONG. REC. S3580 (daily ed. Mar. 12, 2003) (rejecting the motion).

[29] In urging the House Judiciary Committee to defeat a proposed amendment that would have added a health exception to the Act, Representative Chabot, the sponsor of the Act in the House, stated, "a health exception, no matter how narrowly drafted, gives the abortionist unfettered discretion in determining when a partial-birth abortion may be performed. And abortionists have demonstrated that they can justify any abortion on this ground. . . . It is unlikely then that a law that includes such an exception as being proposed would ban a single partial-birth abortion or any other late-term abortion." H.R. Rep. No. 108-58, at 69 (statement of Rep. Chabot). Similarly, in arguing against a health exception amendment on the Senate floor, Senator Santorum, the Act's main sponsor in the Senate, asserted, "In practice, of course, health means anything, so there is no restriction at all." 149 CONG. REC. S3607 (daily ed. Mar. 12, 2003) (statement of Sen. Santorum). Senator Santorum later argued that "health" is a "term—in fact, the courts have interpreted it to mean anything" and that a health

abortion" ban *with no health exception* was clearly one of Congress's primary motivations in passing the Act.

In light of this legislative history, it would be improper for us to issue an injunction that essentially adds a health exception to the statute—an exception that Congress purposefully excluded from the Act. When Congress deliberately makes a decision to omit a particular provision from a statute—a decision that it is aware may well result in the statute's wholesale invalidation—and when it defeats multiple amendments that would have added that provision to the statute, we would not be faithful to its legislative intent were we to devise a remedy that in effect inserts the provision into the statute contrary to its wishes. Such an action would be inconsistent with our proper judicial role.

Our inquiry as to whether the legislature would have "preferred what is left of its statute to no statute at all," *Ayotte*, at 968, does not change our conclusion. Given the record before us, it is impossible to say that Con-

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exception "frankly, swallows up any limitation, restriction on abortion." 149 CONG. REC. S3590 (daily ed. Mar. 12, 2003) (statement of Sen. Santorum). A co-sponsor of the Act, Senator DeWine, argued that because of the way "health of the mother" has been defined by the Supreme Court, an exception to protect it would mean "almost any excuse would be enough to justify a late-term partial-birth abortion. Yet the abortionist would be within the law because he determined the health of the mother was at risk." 149 CONG. REC. S3605 (daily ed. Mar. 12, 2003) (statement of Sen. DeWine). Representative Sensenbrenner, a co-sponsor of the Act, made similar comments in arguing against a health exception amendment. He stated, "Abortionists have demonstrated that they can and will justify any abortion on the grounds that it, in the judgment of the attending physician, is necessary to avert serious adverse health consequences to the woman." 149 CONG. REC. H4940 (daily ed. June 4, 2003) (statement of Rep. Sensenbrenner).

gress would have preferred the Act with a health exception engrafted upon it to no statute at all. The creation of legislation is a fundamental part of the political process, to be performed by the elected branches only. In deciding whether to adopt legislation on highly controversial issues, elected officials must weigh various factors and make informed political judgments. When, in such cases, it is not possible to achieve the full legislative goal, the leaders of the battle may prefer to drop the legislation entirely in order to be able to wage a more dramatic and emotional campaign in the public arena. They may conclude that leaving an issue completely unaddressed will make it easier for them to achieve their ultimate goals than would a partial resolution that leaves their "base" discontented and disillusioned. Dropping the proposed legislation (or even having it defeated) may be the best way to gain adherents to the cause, inspire the faithful, raise funds, and possibly even generate support for a constitutional amendment. Conversely, the sponsors of a bill may consider a partial victory worthless from a political standpoint, as the sponsors of the Partial-Birth Abortion Ban Act told their fellow members of Congress here, or they may just object strongly to such a solution from a moral or even a religious standpoint. Particularly when an issue involving moral or religious values is at stake, it is far from true that the legislative body would always prefer some of a statute to none at all.

Abortion is an issue that causes partisans on both sides to invoke strongly held fundamental principles and beliefs. We are prepared to deal with the constitutional issues relating to that subject, but not with the question how either side would exercise its moral and other judgments with respect to tactical political deci-

sions. Whether the congressional partisans who supported the Act would have preferred to have what they repeatedly and unequivocally deemed to be ineffective legislation or to do without the statute and preserve the status quo ante as a political and moral tool is a determination we are simply unable and unwilling to make.

In any event, we need not rest our decision as to the appropriate remedy solely on the omission of a health exception because we have determined that the Act is unconstitutional on other grounds as well—on the grounds that it imposes an undue burden on women seeking abortions and that it is impermissibly vague. Along with the omission of the health exception, the nature of these constitutional errors precludes us from devising a remedy any narrower than the invalidation of the entire statute, for a number of reasons. First, in order to cure the constitutional infirmities, we would in effect have to strike the principal substantive provision that is now in the Act and then, akin to writing legislation, adopt new terms with new definitions and new language creating limitations on the Act's scope. Second, creating relief that would limit the Act sufficiently to enable it to pass constitutional muster would require us to make decisions that are the prerogative of elected officials and thus would be inconsistent with the proper distribution of responsibilities between the legislative and judicial branches. Third, the magnitude of the change in the Act's coverage that would be necessary to make the Act even potentially constitutional would result in a statute that would be fundamentally different from the one enacted. Fourth, devising narrowing relief of this type would be unfaithful to Congress's intent in passing the Act.

Our conclusions regarding the undue burden imposed by the Act and the Act's impermissible vagueness were based on our determination that the Act's definition of "partial-birth abortion" covers both forms of the D & E procedure; at the very least, we said, the statute does not adequately distinguish between those forms. Significantly, the two forms of D & E constitute the means by which the vast majority of post-first trimester previability abortions are conducted. Remedying the problem of the Act's scope is not a simple matter of striking a portion of the statutory language, however, or of drafting an injunction that performs that function. Nor is the existing statutory language susceptible to a simple limiting construction. In order to remedy the constitutional problems with the Act's definition of "partial-birth abortion," we would essentially have to "rewrite [the statutory language] to conform it to constitutional requirements," a task the Court has cautioned we should not undertake. *Ayotte*, at 968 (quoting *Am. Booksellers Ass'n*, 484 U.S. at 397, 108 S. Ct. 636).

Furthermore, before we could even begin the task of rewriting the statute so as to arrive at an adequate injunctive order, we would first have to decide which of the different methods of performing post-first trimester previability abortions should be prohibited by the revised Act.[30] We are not willing to make such choices for four reasons. First, doctors disagree about the medical necessity and effects of each of the methods. The

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[30] Induction is the method used to perform most post-first trimester previability abortions not done by D & Es. Because of the Act's failure to differentiate between intact and non-intact D & E, which we held sufficient to create an undue burden, we did not reach the issue whether the Act's definition of the prohibited procedures also encompasses induction, although it might well do so.

decision regarding which of these methods to regulate is a *policy* choice that only Congress can make.[31] Second, choosing which methods to regulate would require us to draw lines between different abortion procedures with which we are not "intimately familiar," another factor cautioning against our attempting to create a narrow remedy.[32] Third, determining whether to cover particular forms or procedures would raise unresolved constitutional questions that we need not otherwise decide on this appeal.[33] For example, neither this court nor the Supreme Court has previously decided whether a statute that bans only intact D & E would be constitutional. *See* note 18 *supra*. Fourth, even if Congress would have preferred an injunction that made the controversial policy choices we would be required to make and even if Congress would have preferred the substantial alteration of the statute to its total invalidation, it is contrary to the appropriate allocation of legislative *and*

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[31] *See Denver Union Stock Yard Co. v. Producers Livestock Mktg. Ass'n*, 356 U.S. 282, 289, 78 S. Ct. 738, 2 L. Ed. 2d 771 (1958) ("[Courts] should guard against the danger of sliding unconsciously from the narrow confines of law into the more spacious domain of policy" (internal quotation marks and citations omitted)).

[32] *See United States v. Nat'l Treasury Employees Union*, 513 U.S. 454, 479 n.26, 115 S. Ct. 1003, 130 L. Ed. 2d 964 (1995) (refusing to "rewrite the statute" because, *inter alia*, "[d]rawing a line between a building and sidewalks with which we are intimately familiar . . . is a relatively simple matter. In contrast, drawing one or more lines between categories of speech covered by an overly broad statute . . . involves a far more serious invasion of the legislative domain.").

[33] *See id.* at 479, 115 S. Ct. 1003 (rejecting a narrower remedy than complete invalidation of a statute because, *inter alia*, creating it would require the court to choose among policy alternatives that "would likely raise independent constitutional concerns whose adjudication is unnecessary to decide this case").

judicial functions for Congress to have "covered the waterfront" and left the job of selecting the conduct that could properly be prohibited to us. As *Ayotte* reiterated, Congress may not " 'set a net large enough to catch all possible offenders, and leave it to the courts to step inside' to announce to whom the statute may be applied." Slip op. at 8 (quoting *United States v. Reese*, 92 U.S. 214, 221, 23 L. Ed. 563 (1876)). Here, Congress, notwithstanding existing Supreme Court law and the multiple opportunities it was given to limit the Act's scope, passed an overly broad ban that it was aware likely violated the Constitution as construed by the Court. In so doing, Congress left it to the judiciary to sort out which parts of the statute are constitutional and which are not. This is precisely what *Ayotte* reminded us Congress may not do. Narrowing the statute is "quintessentially legislative work" that, if undertaken by us, would exceed "our constitutional mandate and institutional competence." *Ayotte*, at 968.[34]

Even if we could, consistent with the judiciary's proper role, choose which procedures to prohibit, the only options that stand a chance of passing constitutional muster would leave us with an Act of a drastically more limited scope than the current one. Because the Supreme Court has held that a statutory prohibition that covers both intact and non-intact D & Es is unconstitutional, *Stenberg*, 530 U.S. at 938-46, 120 S. Ct. 2597, the only possibly constitutional regulation would be a prohibition limited to the intact D & E procedure

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[34] A further indication that narrowing would not be faithful to legislative intent is the absence from the Act of a severability clause. *Ayotte* pointed to the presence of such a clause as an indication that a narrower remedy is consistent with legislative intent. Slip. op at 9-10.

(and possibly induction). Even assuming that such a regulation would be constitutional (*but see supra* note 18), an injunction that so limited the statute would outlaw only a very small portion of the procedures prohibited under the existing Act. Such an injunction would radically change the nature of the statute and result in a regulatory scheme substantially different from the one passed by Congress. When a "narrow" remedy would substantially change the very nature of a statute, adopting that remedy exceeds the proper judicial role.[35]

Finally, we believe that devising a narrow remedy would not be "faithful to legislative intent." *Ayotte*, at 969. Congress did not unintentionally draft the broad definition of "partial-birth abortion" that gives rise to the undue burden and vagueness concerns, nor did it write the unconstitutionally overbroad language without the benefit of judicial guidance. Instead, Congress chose not to follow the roadmap the Court provided in *Stenberg*. It repeatedly dismissed warnings that the Act's overly inclusive scope made it vulnerable to constitutional challenge.[36] Even if we could draft a

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[35] *See Sloan v. Lemon*, 413 U.S. 825, 834, 93 S. Ct. 2982, 37 L. Ed. 2d 939 (1973) (striking down entire Pennsylvania tuition reimbursement statute because to eliminate only unconstitutional applications "would be to create a program quite different from the one the legislature actually adopted"), *cited in United States v. Booker*, 543 U.S. 220, 125 S. Ct. 738, 758, 160 L. Ed. 2d 621 (2005).

[36] As in the case of the health exception, Congress rejected repeated warnings of unconstitutionality, this time that the Act's language was too broad. It ignored admonitions to follow the Court's roadmap by defining the prohibited procedure using the medical terms for intact D & E. Senator Feinstein, for example, stated, the Act "attempts to ban a specific medical procedure which it calls partial-birth abortion. But the bill offers no medical

definition of partial-birth abortion." She then questioned the Act's sponsors' refusal to use such a definition. She asked, "Why wouldn't the proponents of this bill put in a medically acceptable definition so that those physicians who were practicing medicine and may encounter this kind of case would know precisely what is prohibited? I believe I know the answer. The answer is that the bill is calculated to cover more than just one procedure. . . . I believe if the bill becomes law, it would be struck down as unconstitutional." 149 CONG. REC. S3601 (daily ed. Mar. 12, 2003) (statement of Sen. Feinstein); *see also* 149 CONG. REC. S3600 (daily ed. Mar. 12, 2003) (statement of Sen. Feinstein) ("[The Act] is not what it purports to be. It supposedly bans one procedure, D & X, but actually confuses this procedure with another, D & E, the most commonly used abortion procedure. In fact, its wording is so vague that it could be construed to criminalize all abortions."). Other members of Congress also asserted that the Act's definition of the banned procedure was overly broad and ignored the Court's guidance in *Stenberg*. Representative Farr explained, "The definition of the banned procedure in [the Act] is vague and could be interpreted to prohibit some of the safest and most common abortion procedures that are used before viability during the 2nd trimester. This legislation could have been written using precise, medical terms. . . ." 149 CONG. REC. H4933 (daily ed. June 4, 2003) (statement of Rep. Farr). Similarly, Senator Boxer stated, "What we have is the *Stenberg* case that ruled that the Nebraska statute was unconstitutional because it placed an undue burden on women because the definition is vague and there is no exception to protect women's health. Lawyers and constitutional experts tell us that the same problem exists in [the Act]." 149 CONG. REC. S3561 (daily ed. Mar. 12, 2003) (statement of Sen. Boxer). Representative Conyers stated, "It is unclear what types of procedures are covered by the legislation. Although some believe the legislation would apply to an abortion technique known as 'Dilation and Extraction' (D & X), or 'Intact Dilation and Evacuation,' it is not clear the term would be limited to a particular and identifiable practice. . . . [The Act] could well apply to additional abortion procedures known as D & E (Dilation and Evacuation), and induction." 149 CONG. REC. H4934 (daily ed. June 4, 2003) (statement of Rep. Conyers). *See also, e.g.*, 149 CONG. REC. S3424 (daily ed. Mar.

remedy that sufficiently restricted the scope of the statute (which we believe we could not properly do consistent with our limited judicial role), such a narrowing construction would serve not to cure an error but to reverse a political judgment that Congress expressly made. Nor can we say that Congress would have preferred any such narrowing construction to no statute at all. For reasons discussed above, we are not capable of making the judgment that, in the eyes of Congress, legislation restricted to non-intact D & Es would have been preferable to no legislation at all. We believe that a narrow remedy designed to address the undue burden and vagueness concerns, as well as the health exception, would likely violate Congress's intent in passing the Act.

11, 2003) (statement of Sen. Murray) ("[T]he language is so broad that it bans other constitutionally protected procedures. The Supreme Court's rulings state: 'Even if the statute's basic aim is to ban D & X, its language makes clear it also covers a much broader category of procedures.' The bill before us is similarly unconstitutional because it covers too many constitutionally protected procedures."); 149 CONG. REC. S3611-12 (daily ed. Mar. 12, 2003) (statement of Sen. Feingold) ("Congress should seek to regulate abortions only within the constitutional parameters set forth by the U.S. Supreme Court. Yet in light of the Supreme Court's 2000 decision [in *Stenberg*], the bill before us today . . . is unconstitutional on its face. It is so vague and overbroad that it, too, could unduly burden a woman's right to choose prior to viability."); 149 CONG. REC. S3576 (daily ed. Mar. 12, 2003) (statement of Sen. Mikulski) ("[The Act] does not clearly define the procedure it claims to prohibit. Let me be clear about this. The [Act] is unconstitutional."); 149 CONG. REC. S3481 (daily ed. Mar. 11, 2003) (statement of Sen. Durbin); 149 CONG. REC. H4934 (daily ed. June 4, 2003) (statement of Rep. Stark); 149 CONG. REC. H4937 (daily ed. June 4, 2003) (statement of Rep. Jackson Lee).

We are reluctant to invalidate an entire statute. However, after considering all of the obstacles to our devising a narrower remedy, we conclude that such is our obligation. Accordingly, we uphold the district court's order permanently enjoining enforcement of the Act in its entirety.

V. Conclusion

The Act lacks the health exception required of all abortion regulations in the absence of a medical consensus that the prohibited procedure is never necessary to preserve women's health, imposes an undue burden on a woman's right to choose a previability abortion, and is impermissibly vague. For each of these reasons, independently, we hold that the Act is unconstitutional. We also hold that, in light of all the circumstances, the appropriate remedy for the serious constitutional flaws in the Act is that which the district court elected: to enjoin the enforcement of the statute in its entirety. The judgment of the district court is **AFFIRMED**.

APPENDIX B

UNITED STATES DISTRICT COURT FOR THE
NORTHERN DISTRICT OF CALIFORNIA

No. C 03-4872 PJH

PLANNED PARENTHOOD FEDERATION OF AMERICA, ET AL., PLAINTIFFS

v.

JOHN ASHCROFT, ATTORNEY GENERAL OF THE UNITED STATES, IN HIS OFFICIAL CAPACITY, DEFENDANT

CITY AND COUNTY OF SAN FRANCISCO, PLAINTIFF INTERVENOR

v.

JOHN ASHCROFT, ATTORNEY GENERAL OF THE UNITED STATES, IN HIS OFFICIAL CAPACITY, DEFENDANT

June 1, 2004

ORDER GRANTING PERMANENT INJUNCTION; FINDINGS OF FACT AND CONCLUSIONS OF LAW IN SUPPORT THEREOF

HAMILTON, District Judge.

INTRODUCTION

Before this court is the constitutionality of the Partial-Birth Abortion Ban Act of 2003 ("Act"). With the Act, Congress seeks to ban an abortion procedure it

refers to as "partial-birth abortion." The Act is very similar to a prior Nebraska statute banning so-called "partial-birth abortions," which the United States Supreme Court held unconstitutional. *See Stenberg v. Carhart*, 530 U.S. 914, 120 S. Ct. 2597, 147 L. Ed. 2d 743 (2000). Plaintiffs in this case seek an injunction permanently enjoining enforcement of the Act.

For the reasons that follow, this court concludes that the Act is unconstitutional, and PERMANENTLY ENJOINS enforcement of the Act.[1]

BACKGROUND

I. *FACTUAL BACKGROUND*

The Act at issue in this case imposes criminal and civil penalties on "[a]ny physician who, in or affecting interstate or foreign commerce, knowingly performs a partial-birth abortion." 18 U.S.C. § 1531(a). A brief summary of the various abortion procedures is set forth below to aid in an understanding of the Act's scope and the procedure or procedures that it prohibits.[2]

A. Established Abortion Procedure

A full-term pregnancy lasts for approximately 40 weeks, measured from the date of the woman's last menstrual period ("lmp").[3] Traditionally, pregnancy is

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[1] The court would like to take this opportunity to express its appreciation for the high quality of advocacy and the degree of professionalism and courtesy exhibited by all counsel.

[2] In discussing the background regarding abortion procedures generally, the court relies in part on the testimony of the parties' experts. The background and qualifications of those experts is set forth in this court's findings of fact regarding the necessity of a medical exception. *See* fn 16 below.

[3] All gestational ages in this order are dated from lmp unless otherwise indicated. Some doctors date gestational age by the

divided into three trimesters, with the first trimester lasting until about the 13th or 14th week of pregnancy, the second lasting until about the 27th week, and the third lasting until birth. *See, e.g.*, Trial Transcript ("Tr.") Vol. 1 at 14:2-20 (Paul). A fetus is considered viable, meaning that it has a realistic chance of long-term survival outside the uterus, at approximately 24 weeks lmp. Tr. Vol. 1 at 14:21-15:5 (Paul); Tr. Vol. 7 at 1119:23-1120:3 (Sprang), Tr. Vol. 9 at 1355:18-22 (Cook, finding viability at 23 weeks).

If a woman chooses to terminate her pregnancy, a doctor will use different medical techniques depending on the gestational age of the fetus. Second trimester abortions, the main subject of this litigation, generally involve one of two procedures: dilation and evacuation ("D & E," or surgical abortion) or induction (which is also known as a medical abortion, meaning that drugs are administered to abort the pregnancy).[4] Other methods that are used much more rarely are hysterotomy (the caesarean removal of the fetus from the uterus) and hysterectomy. Tr. Vol. 1 at 44:7-47:2, 46:8-46:22 (Paul); Exh. 7 (table 16).

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date of conception, which is approximately two weeks after a woman's last menstrual period. *See* Tr. Vol. 10 at 1614:14-23 (Anand).

[4] As of 2000, first trimester abortions make up approximately 85% of the 1.3 million abortions performed per year in the United States. Exh. 7 at 31 ("Abortion Surveillance—United States 2000," compiled by the Centers for Disease Control; table 16); *see also* Tr. Vol. 1 at 38:6-42:24 (Paul). For first trimester abortions, the doctor will either perform an early medical abortion (up to 9 weeks) or a vacuum aspiration abortion (which is also known as dilation and curettage, or D & C). Tr. Vol. 1 at 43:18-44:6 (Paul). These procedures are not at issue here.

1. D & E

A D & E abortion is a surgical procedure, which is performed in two steps: dilation of the cervix and surgical removal of the fetus. *See, e.g.*, Tr. Vol. 1 at 50:10-15 (Paul). About 85-95% of all second trimester abortions performed in the United States are D & Es. Tr. Vol. 1 at 48:24-49:17 (Paul); Trial Exhibit ("Exh.") 7 (table 18) (noting that D & Es make up 95% of all abortions taking place between 16 and 20 weeks of pregnancy, and 85% of all abortions taking place after 20 weeks); Tr. Vol. 5 at 804:2-3 (Westhoff).[5]

To begin the D & E process, the woman's cervix is first dilated with osmotic dilators used either alone or in conjunction with drugs known as prostaglandins (or misoprostyl).[6] This encourages the cervix to expand in width and shorten in length, as if in preparation for labor, and will permit the doctor to introduce surgical instruments into the woman's uterus. Tr. Vol. 1 at 50:25-62:6 (Paul); Tr. Vol. 1 at 167:5-10 (Sheehan); Tr. Vol. 3 at 400:18-402:22(Doe); Tr. Vol. 4 at 509:4-511:19 (Broekhuizen); Tr. Vol. 4 at 657:13-662:25 (Creinin); Tr. Vol. 5 at 811:18-812:20 (Westhoff), Tr. Vol. 11 at 1718:4-

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[5] Doctors report that women appear to strongly prefer D & E abortions to inductions for a variety of reasons, including the fact that a D & E is significantly quicker than an induction, does not require a hospital stay, and does not require that the woman go through labor to end the pregnancy. *See, e.g.*, Tr. Vol. 1 at 91:17-92:1 (Paul), Tr. Vol. 3 at 457:1-458:10 (Doe); Tr. Vol. 4 at 503:22-504:3 (Broekhuizen); Tr. Vol. 5 at 804:2-5 (Westhoff); Tr. Vol. 11 at 1773:23-1776:10 (Chasen); Tr. Vol. 6 at 946:24-947:3 (Bowes).

[6] Sometimes the misoprostyl will result in uterine contractions, which may result in either the partial or complete delivery of the fetus before any surgery takes place. *See, e.g.*, Tr. Vol. 1 at 59:16-60:17 (Paul); Tr. Vol. 3 at 405:4-6 (Doe); Tr. Vol. 4 at 511:23-512:25 (Broekhuizen).

1720:10 (Chasen). Doctors need more dilation as gestational age increases, and generally try to achieve a minimum of one millimeter of dilation for each week of gestation (for example, a doctor would try to achieve 20 millimeters, or 2 centimeters, of dilation for a 20 week fetus). Tr. Vol. 2 at 182:6-14 (Sheehan); Tr. Vol. 3 at 402:3-5 (Doe); Tr. Vol. 4 at 661:22-662:1 (Creinin).[7] However, the amount of cervical dilation that can be achieved is individual to each woman and cannot necessarily be controlled. Tr. Vol. 1 at 55:8-14 (Paul); Tr. Vol. 2 at 14-15 (Sheehan); Tr. Vol. 3 at 402:10-18 (Doe); Tr. Vol. 8 at 1283:3-8 (Shadigian); Tr. Vol. 4 at 661:19-21 (Creinin). For instance, women who have previously undergone childbirth often will achieve greater dilation in a shorter period of time than women who have not. Tr. Vol. 1 at 62:2-5 (Paul); Tr. Vol. 2 at 182:20-183:1 (Sheehan); Tr. Vol. 4 at 662:2-9 (Creinin); Tr. Vol. 5 at 812:12-13 (Westhoff); Tr. Vol. 11 at 1723:17-1724:6 (Chasen).

Dilation can take place over a period of time ranging from 90 minutes up to one or two days, depending on the practice of the physician. The process can be accelerated if drugs to induce dilation are administered along with the placement of laminaria in the cervix. Tr. Vol. 1 at 55:4-7, 59:9-11 (Paul, using a half to one-day dilation procedure); Tr. Vol. 1 at 180:21-183:10 (Sheehan, using a two-day dilation procedure); Tr. Vol. 3 at 401:7-402:22 (Doe, using a one-day dilation procedure);

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[7] By comparison, the vaginal delivery of a full-term fetus requires 10 centimeters of dilation. No doctor would dilate a woman's cervix to that extent for the purpose of performing a surgical abortion. *See* Tr. Vol. 4 at 544:17-545:4 (Broekhuizen stating the maximum dilation he would seek is 6-7 centimeters for an induction abortion, which requires more dilation than a D & E).

Tr. Vol. 4 at 659:23-24 (Creinin, using a one-day dilation procedure); Tr. Vol. 5 at 812:6-812:20 (Westhoff, using a two day-dilation procedure); Tr. Vol. 11 at 1719:10-25 (Chasen, using a two-day dilation procedure). If the doctor opts to perform dilation over an extended period of time, the procedure often takes place in an outpatient setting, so the woman can participate in her usual daily activities and spend the night at home. *See, e.g.*, Tr. Vol. 1 at 45:15-19, 60:1-6 (Paul); Tr. Vol. 2 at 181:11-14 (Sheehan); Tr. Vol. 3 at 402:21-22 (Doe); Tr. Vol. 4 at 659:25-660:5 (Creinin).

The woman then returns to the clinic or hospital the next day, and, if sufficient dilation has been achieved, she is then placed under some form of sedation, and the cervix is prepared for surgery.[8] The doctor will then place forceps in the uterus, and, usually under ultrasound guidance, grasp the fetus with the forceps and then remove the fetus by pulling it through the cervix and vagina. This process usually causes the fetus to disarticulate. It usually takes about 10-15 "passes" through the uterus to remove the entire fetus. When the entire fetus has been removed, the doctor then uses a suction tube, or cannula, to remove the placenta from the uterus and to ensure that no fetal parts have been left behind. Tr. Vol. 1 at 62:7-68:21, 69:9-21 (Paul); Tr. Vol. 2 at 183:15-186:13 (Sheehan); Tr. Vol. 3 at 402:23-404:12 (Doe); Tr. Vol. 4 at 514:20-526:17 (Broekhuizen); Tr. Vol. 4 at 663:1-668:4 (Creinin); Tr. Vol. 5 at 812:21-818:7 (Westhoff). All the testifying experts who per-

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[8] If the doctor believes the cervix has not sufficiently dilated for the procedure to be performed, the doctor may place more dilators in the cervix and wait another day before beginning the surgical portion of the abortion. *See, e.g.*, Tr. Vol. 4 at 518:23-519:2 (Broekhuizen); Tr. Vol. 4 at 660:23-661:14 (Creinin).

form this procedure use ultrasound to provide visual guidance for second trimester abortions. Tr. Vol. 1 at 67:6-7 (Paul); Tr. Vol. 1 at 168:6-13 (Sheehan); Tr. Vol. 3 at 403:16-19(Doe); Tr. Vol. 4 at 515:15-24 (Broekhuizen); Tr. Vol. 4 at 668:13-17 (Creinin); Tr. Vol. 11 at 1721:11-15 (Chasen).

This process takes between 10-15 minutes on average, and can take place either in an outpatient setting or in a hospital. Tr. Vol. 1 at 62:8-9, 73:2-4 (Paul); Tr. Vol. 2 at 186:12-13 (Sheehan); Tr. Vol. 3 at 407:24-408:1 (Doe); Tr. Vol. 4 at 524:11-14 (Broekhuizen, averaging 10-15 minutes, but noting range of 5 to 40 minutes); Tr. Vol. 5 at 741:5-742:2 (Creinin, averaging 10-15 minutes, but noting range of up to 40 minutes).

Some doctors, but not all, also give an injection of either digoxin or potassium chloride ("KCl") either directly into the fetus' heart or in the amniotic fluid surrounding the fetus to effect fetal demise before the procedure is commenced. *Compare* Tr. Vol. 2 at 16-196:6 (Sheehan, who routinely offers digoxin); Tr. Vol. 4 at 561:15-562:22 (Broekhuizen) *with* Tr. Vol. 2 at 328:24-329:18 (Drey, who only offers digoxin when specifically requested to do so), Tr. Vol. 3 408:7-13, 416:14-419:19 (Doe, who does not routinely effect fetal demise before procedure); Tr. Vol. 5 at 819:20-820:5 (Westhoff); Tr. Vol. 11 at 1780:20-1782:21 (Chasen).

2. Induction

The second-most common method of second trimester abortion is induction. About 5% of all second trimester abortions from 14-20 weeks are by induction; after 20 weeks, that percentage increases to 15%. Tr. Vol. 1 at 48:24-49:17 (Paul); Exh. 7 (table 18).

Since the uterus in the second trimester of pregnancy is not inclined to expel the fetus, contractions must instead be artificially induced through the use of chemical agents. In an induction, the woman is given medication to induce labor to expel the fetus. Inductions were previously triggered by saline injections into the uterus, but the most current medical techniques now call for the administration of misoprostyl or oxytocin to induce contractions and labor. Tr. Vol. 3 at 409:4-409:21 (Doe); Tr. Vol. 4 at 527:6-529:20 (Broekhuizen, noting that "We are kind of overriding nature because . . . there are usually signals at this time that suppress uterine activity"); Tr. Vol. 5 at 15:20 (Creinin, "We have to give very high doses of medicines, much higher than you would give at term, just because we are trying to override the fact that the uterus doesn't want to do this process. So you have to make the uterus contract so strongly that it can break apart"); Tr. Vol. 11 at 1777:12-1778:9 (Chasen); *see also* Tr. Vol. 6 at 948:3-9, 950:5-15 (Bowes). *But see* Tr. Vol. 7 at 1093:1-7 (Sprang, testifying induction is more natural); Tr. Vol. 9 at 1391:21-1392:19 (Cook).

An induction abortion takes anywhere from 6 to 48 hours to complete, and in ten percent of inductions, the woman must also undergo a D & E to remove unexpelled matter from the uterus (usually the placenta): Tr. Vol. 3 at 409:18-410:9, 414:3-7 (Doe, stating that most inductions occur within 24 hours and noting complications); Tr. Vol. 4 at 527:6-532:13 (Broekhuizen, giving range of time as 8 to 72 hours, and discussing possible complications requiring subsequent D & E); Tr. Vol. 5 at 715:8-24 (Creinin); Tr. Vol. 8 at 1268:18-21, 1287:19-1289:5 (Shadigian) (stating that most inductions take place between 4 and 24 hours but can take up to 2

and a half days). Because an induction requires around-the-clock monitoring for at least 24 hours, these abortions can take place only in a hospital setting. Tr. Vol. 1 at 45:20-46:7 (Paul); Tr. Vol. 4 at 526:8-527:2 (Broekhuizen).

An induction is more likely to result in the delivery of an intact fetus, so when a fetal autopsy might be needed, doctors will recommend this procedure. Tr. Vol. 3 at 408:14-409:3 (Doe); Tr. Vol. 9 at 1399:11-1400:4 (Cook). However, if the induction takes too long to complete, the fetal tissue breaks down and becomes unuseable for medical study. Tr. Vol. 11 at 1758:7-19 (Chasen).

3. Hysterotomy and Hysterectomy

Two other methods of second trimester abortion are also available, but are very rarely used. A hysterotomy, like a caesarean delivery, involves the surgical removal of the fetus through an incision in the uterus, and a hysterectomy involves the removal of the woman's entire uterus. Tr. Vol. 1 at 46:8-47:2 (Paul); Exh. 7 (table 18, indicating these procedures make up .01% of all abortions and .07% of all second trimester abortions).

Both of these procedures are considered major surgery and are not recommended except in the case of extreme emergency. *See also, e.g.*, Tr. Vol. 1 at 82:9-12 (Paul, noting that hysterotomy and hysterectomy are not really options because of their high rate of mortality and morbidity); Tr. Vol. 11 at 1767:6-1768:4 (Chasen, stating that hysterotomy and hysterectomy should only be used when fetus must be delivered immediately to save the life or health of the woman); Tr. Vol. 6 at 972:6-8 (Bowes).

B. Contested Abortion Procedure

The government argues that none of these previously-described procedures (1st trimester abortion procedures, D & E, induction, hysterotomy, or hysterectomy) are banned by the Act. Rather, the Act prohibits a specific second trimester abortion technique, which the Act refers to as "partial-birth abortion."

I. The Act

The Act defines "partial-birth abortion" as:

> an abortion in which a physician deliberately and intentionally vaginally delivers a living, unborn child until either the entire baby's head is outside the body of the mother, or any part of the baby's trunk past the navel is outside the body of the mother and only the head remains inside the womb, for the purpose of performing an overt act (usually the puncturing of the back of the child's skull and removing the baby's brains) that the person knows will kill the partially delivered infant, performs this act, and then completes delivery of the dead infant.

Act § 2(1); *see also* 18 U.S.C. § 1531(b) (statutory definition). The term "partial-birth abortion," however, is neither recognized in the medical literature nor used by physicians who routinely perform second trimester abortions. *See, e.g.*, Tr. Vol. 2 at 200:23-201:4 (Sheehan); Tr. Vol. 3 at 420:23-421:2 (Doe); *but see* Tr. Vol. 6 at 901:5-19 (Bowes); Tr. Vol. 8 at 1219:23-1220:8 (Shadigian); Tr. Vol. 9 at 1386:7-1387:7 (Cook) (arguing "partial-birth abortion" is a medically recognized term). The language of the Act obviously omits any reference to D & X, D & E, or "intact" extraction.

2. Dr. Haskell and ACOG

The debate over this procedure appears to have been initiated by a presentation given by Dr. Marvin Haskell in 1992 before the National Abortion Federation ("NAF"). *See* Partial-Birth Abortion Ban Act of 2002: Hearing on H.R. 4965 before the Subcomm. on the Constitution of the House Comm. on the Judiciary, 107th Cong. 2nd Sess at 127-34 (2002) ("Record Exh. C") (copy of article).[9] In that presentation, Dr. Haskell outlined a variant on D & E abortions in which the fetus was removed either intact or nearly intact rather than through disarticulation.[10] To distinguish this variant from the standard D & E by disarticulation, Dr. Haskell coined the term "D & X," or "dilation and extraction." *Id.* at 127.

Dr. Haskell described a procedure in which 1) the woman's cervix is dilated through the use of up to 20-30 osmotic dilators over a two-day period; 2) the physician inserts forceps into the woman's uterus and, if the fetus is not presented in a breech position (feet first), the physician performs an "internal podalic version" of the fetus and inverts the fetus so that it is presenting in a breech position; 3) the fetus is extracted intact through the cervix and vagina until its head, or calvarium, is lodged at the cervical opening, or os; and 4) the physician inserts scissors and a suction cannula into the fetus' skull and drains brain tissue from the calvarium,

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[9] The court takes judicial notice of this article's inclusion in the Congressional Record, but notes also that the article itself was not introduced into evidence at trial.

[10] While Dr. Haskell first outlined this procedure in 1992, other physicians testified that they have practiced some version of intact extraction since the 1970s. Tr. Vol. 2 at 187:15-19 (Sheehan); Tr. Vol. 4 at 584:16-585:3 (Broekhuizen).

which causes the calvarium to collapse to the point at which it can be extracted from the uterus. Record Exh. C at 129-131; *see also, e.g.*, Tr. Vol. 8 at 1219:12-1220:4 (Shadigian), Tr. Vol. 9 at 1386:7-1387:7 (Cook).

In response to the subsequent debate over this procedure, the American College of Obstetricians and Gynecologists ("ACOG") subsequently coined the term "intact D & X," which was defined as: 1) deliberate dilation of the cervix, usually over a sequence of days, 2) internal podalic version of the fetus to a breech position; 3) breech extraction of the fetus up to the calvarium, and 4) the extraction of the fetal cranial contents to permit vaginal delivery of a dead, intact fetus. Cain Depo. 164:8-166:17; Exh. 3; *see also, e.g.*, Tr. Vol. 5 at 735:8-736:2 (Creinin).

3. Trial Testimony

At trial, plaintiffs presented the testimony of a number of physicians who perform D & E abortions by procedures which they believe might violate the Act. Several physicians report that occasionally while performing a D & E, they encounter a situation where they believe it will be possible to remove the fetus either intact or largely intact. This occurs when the woman's cervix is dilated to such a degree that the fetus can be extracted up to the head, in either one or two "passes" with the forceps. The potential for a largely intact removal cannot be ascertained until the surgical procedure has already begun, and depends primarily on how the cervix presents at the commencement of the procedure. Tr. Vol. 1 at 67:24-68:1, 71:17-24 (Paul); Tr. Vol. 2 at 205:16-24, 206:5-13 (Sheehan); Tr. Vol. 3 at 406:24-407:11 (Doe); Tr. Vol. 5 at 784:-786:23 (Creinin); Tr. Vol. 5 at 815:3-816:22, 818:18-21 (Westhoff).

The number of times this occurs varied per doctor, but ranged from between 5% to 33% of all D & Es performed, with most doctors reporting occurrences of around 5-15% of the time.[11] Tr. Vol. 1 at 71:8-19 (Paul, estimating 5-10%); Tr. Vol. 2 at 188:13-12 (Sheehan, reporting approximately 20% the week before); Tr. Vol. 3 at 406:10-16 (Doe, estimating 15-20%).

Notably, since Dr. Haskell's paper and presentation, the process has evolved. While some physicians perform abortions in this circumstance using the four steps outlined by ACOG or Dr. Haskell, many others do not.

Some physicians insert up to 25 osmotic dilators over a two day period (known as "serial dilation") to increase the likelihood of an intact D & E, while others simply proceed as they do for a standard D & E by disarticulation. Some physicians perform podalic version, while others do not. Some physicians puncture the calvarium and suction out the cranial contents, others disarticulate the calvarium and crush it with forceps before extraction, while yet others use forceps to collapse the calvarium while it is still attached. *See, e.g.*, Tr. Vol. 1 69:22-70:6, 78:25-79:7 (Paul, who collapses the attached skull with forceps or disarticulates at the neck); Tr. Vol. 2 at 184:15-17, 193:22-24 (Sheehan, who does same, and does not perform podalic version); Tr. Vol. 3 at 405:19-406:9 (Doe, who disarticulates calvarium and crushes with forceps, and sometimes performs podalic version); Tr. Vol. 4 at 516:8-24, 523:1-524:10, 589:23-590:1, 615:7-13 (Broekhuizen, who sometimes practices serial dila-

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[11] Dr. Sheehan and Dr. Creinin reported that an intact D & E occurred less than 1% of the time, but they were reporting incidents where the entire fetus, including the head, was removed intact. Tr. Vol. 2 at 271:20-272:8 (Sheehan); Tr. Vol. 4 at 784:19-786:19 (Creinin).

tion, sometimes performs podalic version when grasping for fetal part, and punctures calvarium); Tr. Vol. 4 at 668:18-669:19, 680:11-681:1 (Creinin, who performs podalic version and punctures or disarticulates calvarium); Tr. Vol. 5 at 801:22-802:3 (Westhoff, who punctures calvarium); Tr. Vol. 11 at 1718:4-1725:10 (Chasen, who uses up to 25 dilators, performs podalic version, and punctures calvarium).

Furthermore, although Dr. Haskell inserted scissors or trocars by touch, all of the physicians who testified stated that they could see the insertion point, either directly or through ultrasound, before any insertions were made. Tr. Vol. 1 at 67:6-7 (Paul); Tr. Vol. 1 at 168:6-13 (Sheehan); Tr. Vol. 3 at 403:16-19 (Doe); Tr. Vol. 4 at 632:2-8, 638:18-640:7 (Broekhuizen); Tr. Vol. 4 at 682:14-19 (Creinin); Tr. Vol. 5 at 801:25-802:5, 818:8-11 (Westhoff); Tr. Vol. 11 at 1722:10-13 (Chasen).

Most significantly, all of the testifying physicians who have performed intact extractions refer to this procedure as a variant of D & E, and not as an entirely separate procedure. *See, e.g.*, Tr. Vol. 1 at 44:14-45:14 (Paul); Tr. Vol. 2 at 188:20-189:2, 205:16-13 (Sheehan); Tr. Vol. 3 at 406:17-23 (Doe); Tr. Vol. 11 at 1721:16-23, 1723:4-1724:21 (Chasen). The only physicians who referred to it as a separate procedure were witnesses who had never performed the procedure. Tr. Vol. 6 at 959:10-960:3 (Bowes); Tr. Vol. 7 at 1034:8-1035:21, 1094:5-8 (Sprang); Tr. Vol. 8 at 1214:3-1215:3, 1232:14-1233:7 (Shadigian); Tr. Vol. 9 at 1374:4-9, 1380:7-18, 1389:8-13 (Cook). Accordingly, the court will refer to the procedure throughout this order as "intact D & E."

II. *LEGAL FRAMEWORK*

As noted, this case involves an issue similar to that confronted by the Supreme Court in *Stenberg*. In 1997, Dr. Leroy Carhart, a medical doctor who provides late-term abortions, sought a preliminary injunction enjoining Nebraska's "partial-birth abortion" law. Carhart argued that the state's ban subjected women seeking abortions to a significantly greater risk of injury or death than would be the case if he were permitted to perform the banned procedure. The United States District Court for the District of Nebraska granted Carhart's request for a permanent injunction, and the Eighth Circuit affirmed.

The United States Supreme Court subsequently granted certiorari in 2000. *Stenberg*, 530 U.S. at 914, 120 S. Ct. 2597. Before evaluating the Nebraska statute, the Court reiterated the standards for evaluating abortion regulations and restrictions set forth by the Court previously in *Roe v. Wade*, 410 U.S. 113, 93 S. Ct. 705, 35 L. Ed. 2d 147 (1973), and *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 112 S. Ct. 2791, 120 L. Ed. 2d 674 (1992), as follows:

> (1) Prior to viability, a woman has a constitutional right to choose to terminate her pregnancy. *Id.* at 921, 112 S. Ct. 2791. And, while the state has interests in protecting the health of the mother and the potentiality of human life, *see id.*, "[t]he State's interest in regulating abortion previability is considerably weaker than postviability." *Id.* at 930, 112 S. Ct. 2791. Prior to viability, a law that places an "undue burden" on a woman's decision to terminate her pregnancy is unconstitutional. *Id.* at 921, 112 S. Ct. 2791.

(2) Subsequent to viability, the state may regulate and even proscribe abortion "except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." *Id.* (citations omitted).

The *Stenberg* Court subsequently held that the Nebraska statute violated the Fourteenth Amendment on two different bases. First, it concluded that the Nebraska statute was unconstitutional because it lacked any exception for the preservation of the health of the mother. *See id.* at 930-32, 120 S. Ct. 2597. Second, it concluded that the state law placed an undue burden on a woman seeking a previability abortion. *See id.* at 945, 120 S. Ct. 2597.

III. *PROCEDURAL HISTORY*

Approximately three years after the Supreme Court decided *Stenberg*, the 108th Congress passed the final version of the Act, which President George W. Bush signed into law on November 5, 2003. Plaintiffs filed the instant lawsuit, claiming that the Act violates their Fifth Amendment due process rights. At or around the same time that plaintiffs filed their lawsuit with this court, plaintiffs National Abortion Federation, et al., and Dr. Leroy Carhart, plaintiff in the *Stenberg* case, and other physicians, filed similar lawsuits challenging the Act in the United States District Courts for the Southern District of New York ("New York court") and the District of Nebraska ("Nebraska court"), respectively. *See National Abortion Federation v. Ashcroft*, No. 03-8695 RCC (S.D.N.Y.); *Carhart v. Ashcroft*, No. 4:03CV3385 (D. Neb.).

On November 6, 2003, one day after the President signed the Act into law, this court issued an injunction temporarily enjoining enforcement of the Act. The New York and Nebraska courts also temporarily enjoined enforcement of the Act.

At the request of the Attorney General ("the government"), the hearing on the plaintiffs' motion for a preliminary injunction was merged with the trial on the merits, and with the government's consent, the matter was continued for approximately 120 days during which the parties engaged in expedited discovery and trial preparation. On March 19, 2004, the court extended the temporary restraining order to a reasonable time after trial on the merits, for preparation of the instant findings of fact and conclusions of law. Subsequently, on March 29, 2004, the bench trial in this case commenced, lasting approximately three weeks.

In addition to the sizeable Congressional Record submitted by both parties, this court heard testimony from a total of thirteen expert witnesses, and reviewed the deposition testimony of an additional six expert witnesses.

ISSUES

Plaintiffs contend that the Act is unconstitutional, for the following reasons:

(1) the Act places an undue burden on a woman's right to choose;

(2) the Act is impermissibly vague because it fails to clearly define the prohibited medical procedures, thereby depriving physicians of fair notice and encouraging arbitrary enforcement;

(3) the Act's failure to provide an exception for the health of the mother violates a woman's Fifth Amendment due process rights as set forth by the Supreme Court in *Casey* and *Stenberg*; and

(4) the Act violates a woman's due process right to bodily integrity.[12]

DISCUSSION

I. *STANDARD OF REVIEW*

The 108th Congress made numerous findings in support of the Act. The government argues that this court must afford those findings substantial deference, while the plaintiffs, on the other hand, contend that this court need not accord the findings any deference. However, the congressional findings, the deference afforded them, and their interplay with the trial evidence in this case, are relevant primarily with respect to the issue regarding the necessity of a health exception, and are therefore discussed in the context of this court's findings and conclusions in that section below.

The other issues involving the construction and validity of the Act: whether the Act places an undue burden on a woman's right to choose, and the alleged vagueness of the Act, are issues of law, which this court reviews *de novo*. *See, e.g., Taylor v. Delatoore*, 281 F.3d 844, 847 (9th Cir. 2002); *Free Speech Coalition v. Reno*, 198 F.3d 1083, 1090 (9th Cir. 1999) (construction and constitutionality of statute are issues of law reviewed *de novo*). Accordingly, both plaintiffs and the government agree that this court "is tasked with independently determining . . . the [constitutional] validity of

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[12] Because the court finds the Act unconstitutional on the three preceding grounds, it declines to reach this issue.

the [A]ct." *See* Government's January 30, 2004 reply brief at 10; *see also* March 1, 2004 amicus brief at 8 ("this Court must make an independent legal judgment regarding whether the applicable law unduly burdens [a woman's right to terminate her pregnancy]").

The court, therefore, discusses first the issues of undue burden and vagueness, setting forth its findings and conclusions on the issues, and subsequently, turns to the necessity of a health exception. In the section regarding the health exception, the court sets forth its findings of fact based on the trial evidence, and then discusses the legislative history of the Act and the record before Congress supporting the congressional findings. The court then provides its conclusion regarding the deference to be afforded the congressional findings, and its conclusions of law, based on the congressional findings and the evidence before this court, regarding the necessity of a health exception.

II. *UNDUE BURDEN*

A. Introduction

In *Stenberg*, one of the two bases for the Supreme Court's holding that the Nebraska statute was unconstitutional was that the statute " 'impose[d] an undue burden on a woman's ability to choose a D & E abortion, thereby unduly burdening the right to choose abortion itself." *Stenberg*, 530 U.S. at 930, 120 S. Ct. 2597 (citing *Casey*, 505 U.S. at 874, 112 S. Ct. 2791).

The Court noted that an undue burden is created by a law that "has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." *Id.* at 921, 120 S. Ct. 2597. It subsequently held that Nebraska's partial-birth abortion ban posed an unconstitutional undue

burden on a woman's decision because the language of the statute was broad enough that it could be interpreted to include a ban on previability D & Es, the most common second trimester abortion procedure, thereby unconstitutionally placing an obstacle in the path of a woman seeking a previability second trimester abortion. *Id.* at 945, 120 S. Ct. 2597.

B. Parties' Positions

Plaintiffs claim that, similar to the Nebraska statute in *Stenberg*, the Act here poses an undue burden on a woman's decision to have an abortion prior to viability. Plaintiffs contend that the Act likewise bans other safe second trimester procedures, including D & E and induction abortions. They argue that the definition of "partial-birth abortion" in the Act is so broad that any abortion performed by the two safest, most common abortion procedures used in the second trimester of pregnancy, prior to fetal viability—D & E and induction—could proceed so as to violate the Act. Accordingly, plaintiffs assert that the Act is unconstitutional as a matter of law.

Moreover, plaintiffs contend that regardless of any interpretation that the government may advance regarding the procedures banned by the Act, the court must follow the language of the definition of "partial-birth abortion" in the Act. *Stenberg*, 530 U.S. at 942, 120 S. Ct. 2597 (rejecting Nebraska Attorney General's suggestion that the term "partial-birth abortion" is "ordinarily associated with the [intact D & E] procedure" because "[w]hen a statute includes an explicit definition, we must follow that definition even if it varies from that term's ordinary meaning"); *see also Reno v. ACLU*, 521 U.S. 844, 884 n.49, 117 S. Ct. 2329, 138 L. Ed. 2d 874 (1997) (federal courts lack the author-

ity to rewrite a statute to conform it to constitutional requirements).

The government, on the other hand, devoted very little attention to the undue burden issue at trial and in its pre-trial and post-trial submissions to the court. That was in spite of this court's conclusion in its order temporarily enjoining the Act that "the scope of the Act may impermissibly encompass [all] D & E procedures and thus impose an undue burden on a woman's right to choose." *See* November 7, 2003 Order.

Instead, as it did in its papers in opposition to the temporary restraining order, the government continues to mistakenly conflate plaintiffs' undue burden challenge with the issue of vagueness. The government's position is simply that Congress intended to ban only intact D & Es, and that the Act is not vague and should be interpreted to apply only to intact D & E abortions—not to D & Es by disarticulation, inductions, or other abortion procedures. Therefore, according to the government, there can be no undue burden.

The government's approach, however, ignores the fact that the two issues, while somewhat related, are nevertheless distinct. The Act may be unduly burdensome under *Casey*, yet not unconstitutionally vague. For example, this court could find that the Act was sufficiently specific regarding the description of the conduct that violates the Act; however, at the same time, the court could conclude that the prohibited conduct may be interpreted to encompass other safe second trimester abortion procedures besides intact D & E. Accordingly, the court rejects the government's framework for analyzing the undue burden issue.

C. Legal Background

The government misconstrues the test regarding undue burden, narrowing the inquiry to whether the regulation poses a "*significant threat* to the . . . health of a woman." However, as the Supreme Court noted in *Stenberg*, "[a]n 'undue burden is . . . shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.'" 530 U.S. at 921, 120 S. Ct. 2597 (quoting *Casey*, 505 U.S. at 877, 112 S. Ct. 2791).

The Nebraska statute at issue in *Stenberg* proscribed:

> deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child.

530 U.S. at 938, 120 S. Ct. 2597 (quoting Neb. Rev. Stat. Ann. § 28-326(9) (Supp. 1999)).

The state of Nebraska agreed that the statute would impose an undue burden if it applied to the more commonly used D & E procedure as well as to the intact D & E procedure. *Id.* at 938, 120 S. Ct. 2597. However, the state argued that the statute's aim was to ban intact D & E and that the statute differentiated between D & E and intact D & E.

The Supreme Court, however, rejected the state's arguments. The Court held that regardless of the statute's "aim," "its language makes clear that [in addition to intact D & E], it also covers a much broader category of procedures." *Id.* at 939, 120 S. Ct. 2597. It noted that

"[t]he language [of the statute] does not track the medical differences between D & E and [intact D & E] —though it would have been a simple matter . . . to provide an exception for the performance of D & E and other abortion procedures." *Id.*

Moreover, that the state of Nebraska "generally intended to bar intact D & E" could be correct, but according to the Supreme Court was "irrelevant." *Id.* at 939. Instead, the relevant inquiry was "whether the law was intended to apply *only* to [intact D & E]." *Id.* The Court noted that "even were we to grant the [Nebraska] Attorney General's views [regarding the aim of the statute] substantial weight, [the Court] would still have to reject his interpretation [because] it conflicts with the statutory language." *Id.* at 942, 120 S. Ct. 2597.

In holding that the statute constituted an undue burden, the Court further concluded that:

> [U]sing this law some . . . prosecutors . . . may choose to pursue physicians who use D & E procedures, the most commonly used method for performing previability second trimester abortions. All those who perform abortion procedures using that method must fear prosecution, conviction, and imprisonment. The result is an undue burden upon a woman's right to make an abortion decision.

Id. at 945-46, 120 S. Ct. 2597.

D. *Stenberg*: Comparison of Act's Language to Nebraska Statute

In contrast to the Nebraska statute in *Stenberg*, the Act here forbids:

> deliberately and intentionally vaginally deliver[ing] a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus.

18 U.S.C. § 1531(b)(1)(A).

The government correctly notes that the language of the Act differs from the statute in *Stenberg* in three respects: 1) the Act requires delivery of the fetus outside of the mother; 2) the Act specifies the required protruding fetal parts; and 3) the Act proscribes an overt act distinct from the completion of the delivery itself.

i. *Location of Delivered Fetus*

While the Nebraska statute applied where the living fetus or a substantial portion thereof was delivered "into the vagina," the Act here specifies vaginal delivery "outside the body of the mother." Neb. Rev. Stat. § 28-326(9); 18 U.S.C. § 1531(b)(1)(A). The government contends that the constitutional infirmities of the Nebraska statute are avoided because D & Es by disarticulation, as compared to intact D & Es, are generally internal dismemberment procedures, and, as the Act here does not apply to procedures performed internally, it does not encompass D & Es by disarticulation.

ii. *Fetal Parts*

In *Stenberg*, the Nebraska statute required the delivery into the vagina of "a living unborn child or *substantial portion thereof*." Neb. Rev. Stat. § 28-326(9).

The Supreme Court took issue with this language, noting that it could

> not understand how one could distinguish, using this language, between D & E (where a foot or arm is drawn through the cervix) and [intact D & E] (where the body up to the head is drawn through the cervix). Evidence before the trial court makes clear that D & E will often involve a physician pulling a "substantial portion" of a living fetus, say, an arm or leg, into the vagina prior to the death of the fetus.

Stenberg, 530 U.S. at 938-939, 120 S. Ct. 2597.

The Act, on the other hand, specifies vaginal delivery of "a living fetus until, in the case of a head-first presentation, *the entire fetal head* is outside the body of the mother *or* in the case of a breech presentation, *any part of the fetal trunk past the navel* is outside the body of the mother." 18 U.S.C. § 1531(b)(1)(A). The government likewise argues that inclusion of this language avoids the constitutional infirmities in *Stenberg* because the Act provides "a specific anatomic landmark."

iii. *Overt Act*

The language of the Act regarding completion of the abortion also varies somewhat from the Nebraska statute in *Stenberg*. In addition to defining the prohibited procedure, the Act provides that the physician "perform[] the overt act, other than completion of delivery, that kills the partially delivered living fetus." 18 U.S.C. § 1531(b)(1)(B). In comparison, the Nebraska statute defined the prohibited abortion procedure, and with respect to completion of the abortion, provided that the procedure "does kill the unborn child." Neb. Rev. Stat. § 28-326(9).

The government argues that this further distinguishes the Act from the statute in *Stenberg*. It argues that the language distinguishes intact D & Es from other procedures because the specific act to kill the fetus must happen at a particular point and place in time. According to the government, "the fact that during the course of a D & E [by disarticulation] or induction, some 'overt act' is taken to kill a living fetus . . . does not render D & E or induction unlawful" because the overt acts characteristic of the other procedures do not occur under the other requirements specified by the Act.

E. Findings of Fact

This court concludes, however, based on the findings set forth below, that despite linguistic differences between the Nebraska statute in *Stenberg* and the Act, the Act nevertheless poses an undue burden on a woman's right to choose an abortion because the Act encompasses not only intact D & E procedures, but other previability D & E procedures and possibly inductions as well, in violation of the Supreme Court's holding.

Specifically, this court finds, based on the evidence before it, that:[13]

1. Like the Nebraska statute in *Stenberg*, the Act bans abortions performed at any time during a pregnancy, regardless of gestational age or fetal viability. In fact, Congress rejected alternatives and amendments to the Act that would have limited its applicability to viable fetuses. *See* 149 Cong. Rec. S3600 (daily

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[13] As noted previously, the background and qualifications of the experts relied on by the court for the findings that follow are set forth in this court's findings of fact regarding the necessity of health exception.

ed. March 12, 2003) (statement of Sen. Feinstein); 149 Cong. Rec. H4939 (daily ed. June 4, 2003) (statement of Rep. Greenwood); 149 Cong. Rec. H4948 (daily ed. June 4, 2003) (statement of Rep. Baldwin).

2. In performing all D & Es, including D & Es by disarticulation, and inductions, physicians "deliberately and intentionally" extract the fetus from the woman's uterus and through her vagina. Tr. Vol. 1 at 76:19-21 (Paul); Tr. Vol. 2 at 200:23-201:4 (Sheehan); Tr. Vol. 3 at 422:3-12 (Doe); Tr. Vol. 5 at 822:0-823:12 (Westhoff). Extraction of the fetus from the uterus, if brought through the cervix and vagina (as opposed to through an incision in the woman's abdomen), is called a "vaginal delivery." Tr. Vol. 1 at 75:20-76:5 (Paul); Tr. Vol. 3 at 421:6-11 (Doe); Tr. Vol. 5 at 822:20-823:12 (Westhoff).

3. The fetus may still have a detectable heartbeat or pulsating umbilical cord when the uterine evacuation begins in any D & E or induction, and may be considered a "living fetus." Tr. Vol. 1 at 67:3-11; 76:6-18 (Paul); Tr. Vol. 2 at 201:5-8 (Sheehan); Tr. Vol. 3 at 421:12-18 (Doe); Tr. Vol. 5 at 822:20-823:12 (Westhoff); Tr. Vol. 11 at 1783:15- 1786:3 (Chasen).

4. Plaintiffs' and the government's experts agree that in any D & E or induction, a living fetus may be extracted in a breech presentation until some "part of the fetal trunk past the navel is outside the body of the mother." Tr. Vol. 6 at 945:17-21 (Bowes); Tr. Vol. 8 at 1283:17-20 (Shadigian); Lockwood Depo 235:16-24; Tr. Vol. 1 at 77:9-78:13 (Paul); Tr. Vol. 1 at 99:16-2; 201:9-16 (Sheehan); Tr. Vol. 2 at 281:22-282:3 (Drey); Tr. Vol. 3 at 405:4-12; 422:3-19 (Doe); Tr. Vol. 4 at 521:2-15; 551:19-552:4 (Broekhuizen); Tr. Vols. 4 & 5 at 678:23-679:14;

784:3-786:18 (Creinin); Tr. Vol. 5 at 822:20-823:12 (Westhoff); Tr. Vol. 11 at 1783:15-1786:3 (Chasen).

5. In a D & E, this may occur under a variety of scenarios, including when:

(A) on an initial pass into the uterus with forceps, the physician disarticulates a small fetal part, which does not cause immediate demise, and then on a subsequent pass, the fetus is brought out of the cervix past the fetal navel;

(B) on an initial pass into the uterus with forceps, the physician brings out a fetal part—either attached to the rest of the fetus, or not—that is "part of the fetal trunk past the navel," but the extraction does not cause immediate demise;

(C) the physician extracts the fetus intact until the calvarium lodges at the internal cervical opening; or

(D) the physician extracts the fetus intact until "part of the fetal trunk past the navel is outside the woman's body," but it is not extracted so far that the calvarium lodges at the cervical opening.

Tr. Vol. 1 at 77:9-78:13 (Paul); Tr. Vol. 2 at 201:9-202:1; 272:18-22 (Sheehan); Tr. Vol. 4 at 521:2-15; 551:1-18 (Broekhuizen); Tr. Vols. 4 & 5 at 681:8-16; 784:3-786:18 (Creinin); Tr. Vol. 5 at 822:20-824:2 (Westhoff); Tr. Vol. 11 at 1783:15-1784:20 (Chasen).

6. In an induction, this may occur because fetal demise may not have occurred by the time the fetus passes through the woman's cervix and vagina, and is outside the body of the woman past the fetal navel. Tr. Vol. 4 at 530:15-533:6 (Broekhuizen); Tr. Vol. 11 at 1784:21-1786:3 (Chasen).

7. In any D & E or induction, if the fetus has been brought to the point "where any part of the fetal trunk past the navel is outside the body of the mother" or "the entire fetal head is outside the body of the mother," a physician may then, in order to complete the abortion in the safest manner, need to perform an "overt act," short of completing delivery, that the physician knows the fetus cannot survive, if it is still living, and that "kills" the fetus. Lockwood Depo. 235:17-236:2; Tr. Vol. 1 at 79:8-16; 60:13-61:6; 69:22-25 (Paul); Tr. Vol. 3 at 422:3-19 (Doe); Tr. Vol. 4 at 551:19-552:9 (Broekhuizen); Tr. Vol. 4 at 638:10-684:10 (Creinin); Tr. Vol. 11 at 1783:15-1786:3 (Chasen). This "overt act" may include disarticulation, cutting the umbilical cord, or compressing or decompressing the skull or abdomen or other fetal part that is obstructing completion of the uterine evacuation. Tr. Vol. 1 at 61:7-15; 70:1-6; 78:25-79:5 (Paul); Tr. Vol. 2 at 193:5-24; 205:8-15 (Sheehan); Tr. Vol. 3 at 405:13-22 (Doe); Tr. Vol. 4 at 523:1-524:1 (Broekhuizen); Tr. Vol. 5 at 783:15 (Creinin).

8. The procedures described above are performed by the testifying physicians only on previable fetuses. Tr. Vol. 1 at 74:14-80:20 (Paul); Tr. Vol. 2 at 281:15-21 (Drey); Tr. Vol. 3 at 420:9-22 (Doe); Tr. Vol. 4 at 550:18-552:9 (Broekhuizen); Tr. Vol. 4 at 657:3-8 (Creinin); Tr. Vol. 5 at 822:9-824:2 (Westhoff); Tr. Vol. 11 at 1783:15-1786:3 (Chasen).

9. For these reasons, any abortion performed using the D & E or induction method could proceed so as to violate the Act when performed in the safest manner. Tr. Vol. 1 at 92:2-93:4 (Paul); Tr. Vol. 1 at 165:11-21 (Sheehan); Tr. Vol. 2 at 282:20-283:3 (Drey); Tr. Vol. 11 at 1784:15-1786:3 (Chasen).

10. For the same reasons, the Act could also ban the steps that a physician takes when treating a woman who presents in the midst of a spontaneous second trimester miscarriage. Tr. Vol. 4 at 555:7-556:11 (Broekhuizen); Tr. Vol. 4 at 684:11-685:5 (Creinin); Tr. Vol. 5 at 824:4-24 (Westhoff); Tr. Vol. 11 at 1786:4-1787:9 (Chasen).

11. As part of their routine practice, eleven of the experts who testified before this court, including Drs. Paul, Sheehan, Doe, Drey, Broekhuizen, Creinin, Westhoff, Chasen, Hammond, Grunebaum, and Fredriksen, sometimes perform previability abortions, as described above, which would violate the act. Tr. Vol. 1 at 74:14-80:20 (Paul); Tr. Vol. 1 at 165:7-21 (Sheehan); Tr. Vol. 2 at 281:15-21 (Drey); Tr. Vol. 3 at 420:9-22 (Doe); Tr. Vol. 4 at 550:18-552:9 (Broekhuizen); Tr. Vol. 4 at 657:3-8 (Creinin); Tr. Vol. 5 at 822:9-824:2 (Westhoff); Tr. Vol. 11 at 1783:15-1786:3 (Chasen); Exh. 36, Exh. 37, Exh. 38.

12. When beginning a D & E or induction procedure, a physician cannot predict if the procedure will proceed in such a manner that it violates the Act, but the physician knows that is a possibility. Tr. Vol. 1 at 71:17-24 (Paul); Tr. Vol. 2 at 206:1-13 (Sheehan); Tr. Vol. 3 at 420:18-22; 426:5-7 (Doe); Tr. Vol. 4 at 522:4-17 (Broekhuizen); Tr. Vol. 5 at 786:11-23 (Creinin).

13. Accordingly, because physicians may face criminal prosecution under the Act for violative procedures, the nature of which they cannot always predict, the Act would have a significantly negative impact on their practice and their relationships with their patients, and in some circumstances, already has. *See, e.g.*, Tr. Vol. 1 at 74:21-23 (Paul) ("my overriding concern is that if I continue to practice . . . second trimester abortions in

the way I believe is the safest for women, that I could be in prison"); *Id.* at 92:8-13 ("I think [the Act] would have a tremendous impact on my practice. I would be forced with a decision I would have never faced before in medicine and that is as to whether to continue to do procedures in a way that I think are safest for women because if I did so, I would risk imprisonment"); *Id.* at 93:5-12 (Act would undermine fundamental trust that physician has with patient because it would prevent them from giving best possible care); Tr. Vol. 4 at 563:3-16 (Broekhuizen) (the Act would "make it significantly more difficult to provide . . . medically necessary services" and would force him to utilize fetocidal injections more frequently which "may not really be in the best interests of the patients"); Tr. Vol. 11 at 1787:10-23 (Chasen) (fear of committing a criminal act may prevent physicians from giving their full attention while providing care); Tr. Vol. 5 at 820:6-20 (Westhoff) (describing complication that occurred as a result of a D & E performed utilizing fetocidal injection in attempt to avoid Act's coverage); Tr. Vol. 2 at 204:14-205:3 (Sheehan) (the Act "would really cause a significant disruption between [me and] the patient"); Lockwood Depo. 68:2-68:16 (criminal penalties included in Act "further unravel physicians' social contract with patients").

F. Conclusions of Law

Accordingly, the court concludes that the definition of "partial-birth abortion" contained in the Act encompasses several second trimester abortion procedures *in addition* to intact D & E. Physicians may perform each element contained in the Act's definition in any D & E procedure, and in the course of certain induction abortions and treatment of spontaneous miscarriages as well. And, because D & E procedures comprise nearly

85-95% of all second trimester abortions, the Act creates a risk of criminal liability during virtually all abortions performed after the first trimester, and "has the effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." *Stenberg*, 530 U.S. at 921, 120 S. Ct. 2597 (quoting *Casey*, 505 U.S. at 877, 112 S. Ct. 2791). A majority of the physicians who testified noted that because they "fear prosecution, conviction, and imprisonment," the wide net cast by the Act could have and has already had the effect of impacting all previability second trimester abortion services that they provide to their patients. *See id.* at 945-46, 112 S. Ct. 2791.

The government's argument that Congress intended to ban only the intact D & E procedure is not convincing. First, as the Supreme Court noted in *Stenberg* in rejecting a nearly identical argument by the state of Nebraska, if Congress did not intend to prohibit procedures other than intact D & Es, it would have been simple for it to exclude other procedures. *See Stenberg*, 530 U.S. at 939, 120 S. Ct. 2597 ("it would have been a simple matter, for example, to provide an exception for the performance of D & E and other abortion procedures"); *see also Planned Parenthood of Central New Jersey v. Farmer*, 220 F.3d 127, 140 (3rd Cir. 2000) (holding New Jersey partial-birth abortion ban unconstitutional, and noting that "[i]f the Legislature intended to ban only the [intact D & E] procedure, it could easily have manifested that intent either by specifically naming that procedure or by setting forth the medical definition of [intact D & E] utilized by ACOG"); *cf. Women's Medical Prof'l Corp. v. Taft*, 353 F.3d 436, 452-53 (6th Cir. 2003) (holding that Ohio partial-birth abortion ban did not pose an undue burden because it

"avoided the flaws identified in [*Stenberg*] by precisely describing the restricted procedure and explicitly permitting D & E procedures").

Moreover, it does not appear to this court that Congress simply overlooked the *Stenberg* Court's language to this effect. Instead, it appears that Congress intentionally chose *not* to explicitly exclude D & Es. The government presented no evidence to this court that supported its arguments regarding congressional intent, and the Congressional Record suggests the contrary. Within Congress, opponents of the Act pointed out the potential overbreadth of the Act and proposed remedies regarding the scope. They noted that:

> Medical experts testified just yesterday before the Constitution Subcommittee that the definition in the bill could easily be construed to ban the most commonly used second trimester procedure.

H.R. Report No. 108-58, at 80 (2003) ("Record Exh. A"). Congress, however, rejected the related amendments to narrow the scope of the Act.

However, even if it was Congress' intent to limit the ban to intact D & Es, this court, like the Supreme Court in *Stenberg*, is "without power to adopt a narrowing construction of [the statute] unless such a construction is reasonable and readily apparent." 530 U.S. at 944, 120 S. Ct. 2597 (citing *Boos v. Barry*, 485 U.S. 312, 330, 108 S. Ct. 1157, 99 L. Ed. 2d 333 (1988)). Even if this court were to accept the government's argument that the phrase "partial-birth abortion," as used by Congress, is commonly associated with the intact D & E procedure, the use of that phrase does not limit the scope of the Act to intact D & Es. Instead, the phrase "partial-birth abortion" is "subject to the statute's *ex-*

plicit statutory definition," which this court is required to follow even if that definition "varies from the term's ordinary meaning." *Id.* at 942-43, 120 S. Ct. 2597 (citing *Meese v. Keene*, 481 U.S. 465, 484-85, 107 S. Ct. 1862, 95 L. Ed. 2d 415 (1987)); *see also Richmond Medical Center v. Hicks*, 301 F. Supp. 2d 499, 515 (E.D. Va. 2004) (Virginia law posed an undue burden despite fact that it explicitly excepted from coverage "the dilation and evacuation abortion procedure involving dismemberment of the fetus prior to removal from the body of the mother where plain language of the Act [nevertheless] ban[ned] pre-viability D & Es and would cause those who perform such D & Es to fear prosecution, conviction, and imprisonment"). Here, for the reasons discussed above, the Act's statutory definition casts a net wider than intact D & Es, and may include other previability abortion procedures, including D & Es by disarticulation, inductions, and treatment of spontaneous miscarriages.

However, even if this court were to find that linguistic differences in the Act make it less likely that the Act encompasses D & E by disarticulation procedures as did the Nebraska statute in *Stenberg*, this court nevertheless concludes that the Act is unduly burdensome because, even assuming that the Act covers only the intact D & E procedure, the Act does not distinguish between previability and postviability in violation of *Roe* and *Casey*. *See Stenberg*, 530 U.S. at 930, 120 S. Ct. 2597 (the government's "interest in regulating abortion previability is considerably weaker than postviability"). To the extent that a woman seeks or requires an intact D & E abortion prior to viability, this Act would

undoubtedly place a substantial obstacle in her path and decision.[14]

For the reasons stated above, the court finds that the Act is unconstitutional.

III. *CONSTITUTIONAL VAGUENESS*

A. Parties' Positions

Plaintiffs next challenge the Act on the ground that it is void for vagueness, in violation of the Due Process Clause, because the Act fails to clearly define the prohibited medical procedures and does not use terminology that is recognized in the medical community. Therefore, according to plaintiffs, it deprives physicians of fair notice and encourages arbitrary enforcement.[15]

The government, however, contends that the inclusion of scienter requirements in the Act mitigates any possible vagueness. *See, e.g., Village of Hoffman Estates v. Flipside*, 455 U.S. 489, 499, 102 S. Ct. 1186, 71 L. Ed. 2d 362 (1982); *Colautti v. Franklin*, 439 U.S. 379, 395 n.13, 99 S. Ct. 675, 58 L. Ed. 2d 596 (1979). It cites to three statutory phrases in the Act that it contends

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[14] The *Stenberg* court did not have to reach this issue because it concluded that the statute in that case sufficiently encompassed other D & E procedures in addition to intact D & E-procedures. However, as the *Stenberg* court noted, "the fact that Nebraska's law applies both previability and postviability aggravates the constitutional problem presented." *Id.*

[15] Plaintiffs also argue that the Act is impermissibly vague regarding what conduct is "in or affecting interstate or foreign commerce." They contend that physicians, therefore, have no notice regarding when the Act applies, thus subjecting them to arbitrary and discriminatory prosecution. However, because the court concludes that the Act is unconstitutionally vague for the reasons set forth above, it is unnecessary for the court to reach this specific argument.

constitute scienter requirements. These phrases appear in § 1531(a), and in § 1531(b)(1)(A) (defining partial-birth abortion), and provide in pertinent part:

> (a) Any physician who, in or affecting interstate or foreign commerce, *knowingly performs* a partial-birth abortion and thereby kills a human fetus shall be fined under this title or imprisoned not more than 2 years, or both. . . .
>
> (b) As used in this section—
>
> (1) the term "partial-birth abortion" means an abortion in which the person performing the abortion—
>
> (A) *deliberately and intentionally* vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of a breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, *for the purpose of* performing an overt act that the person knows will kill the partially delivered fetus. . . .

(Emphasis added.)

The government contends that the inclusion of these scienter requirements as emphasized above remedies any vagueness. It claims that because of the scienter requirements, "the Act does not criminalize situations, during a D & E [by disarticulation], in which a living fetus may be delivered, by happenstance, intact or even [in] cases where the partial delivery of the intact fetus is intentional or forseeable, but only procedures where the provider deliberately delivers the fetus both in the manner described by the Act and *with* a specific intent

from the outset to perform an overt act that the provider knows will kill the fetus."

B. Legal Standard

The Supreme Court has unambiguously stated that vague laws are unconstitutional:

> It is a basic principle of due process that an enactment is void for vagueness if its prohibitions are not clearly defined. Vague laws offend several important values. First, because we assume that man is free to steer between lawful and unlawful conduct, we insist that laws give the person of ordinary intelligence a reasonable opportunity to know what is prohibited, so that he may act accordingly. Vague laws may trap the innocent by not providing fair warning. Second, if arbitrary and discriminatory enforcement is to be prevented, laws must provide explicit standards for those who apply them.

Grayned v. City of Rockford, 408 U.S. 104, 108, 92 S. Ct. 2294, 33 L. Ed. 2d 222 (1972). Accordingly, to avoid unconstitutional vagueness, the Act must (1) define the offense with sufficient definiteness that ordinary people can understand what conduct is prohibited; and (2) establish standards such that enforcement may be conducted in a non-arbitrary, non-discriminatory manner. *Nunez v. City of San Diego*, 114 F.3d 935, 940 (9th Cir. 1997).

"The need for definiteness is greater when the ordinance imposes criminal penalties on individual behavior or implicates constitutionally protected rights than when it regulates the economic behavior of businesses." *Id.* (quoting *Village of Hoffman Estates*, 455 U.S. at 494, 102 S. Ct. 1186). Moreover, if the Act does not provide sufficient "standards to prevent arbitrary enforce-

ment," it "would be impermissibly vague even if it did not reach a substantial amount of constitutionally protected conduct, because it would subject people to the risk of arbitrary deprivation of their liberty." *Forbes v. Napolitano*, 236 F.3d 1009, 1011-1012 (9th Cir. 2000) (citing *City of Chicago v. Morales*, 527 U.S. 41, 42, 119 S. Ct. 1849, 144 L. Ed. 2d 67 (1999)). "Regardless of what type of conduct the criminal statute targets, the arbitrary deprivation of liberty is itself offensive to the Constitution's due process guarantee." *Id.* at 1012 (citing *Smith v. Goguen*, 415 U.S. 566, 575, 94 S. Ct. 1242, 39 L. Ed. 2d 605 (1974)).

C. Findings of Fact and Conclusions of Law

As plaintiffs note, several of the terms in the Act are ambiguous, including "partial-birth abortion," "overt act," "deliberately and intentionally," and "living fetus." The trial testimony of numerous physicians confirmed that, as physicians and practitioners providing abortion services, they do not understand exactly what the Act prohibits. *See, e.g.*, Tr. Vol. 1 at 76:7-82:12 (Paul); Tr. Vol. 4 at 557:4-13 (Broekhuizen); Tr. Vol. 11 at 1787:10-23 (Chasen); Tr. Vol. 5 at 820:6-20 (Westhoff); Tr. Vol. 2 at 200:23- 202:3 (Sheehan).

As many of the physicians testified before this court, the term "partial-birth abortion" has little if any medical significance in and of itself. *See, e.g.*, Tr. Vol. 3 at 420:23-421:2 (Doe); Grunebaum Depo. at 214:1-7. Dissenting legislators within Congress made the same observation, arguing that:

> This legislation is overly vague. It is unclear exactly, which procedures we would ban. The term 'partial-birth abortion' has no legal or medical meaning. It is a term invented for political purposes. The findings

> and actual operative clauses of the bill are inconsistent in their definitions, and in both cases are overly vague.

Record Exh. A, at 80.

Additionally, the Act's use of the term "living fetus" adds to the vagueness of the statute, since, the term "living fetus" is not pertinent to the framework set forth by the Supreme Court in *Roe* and *Casey*, and does not pertain to viability. As set forth above in the court's findings regarding undue burden, a previable fetus may nonetheless be "living" if it has a detectable heartbeat or pulsating umbilical cord. Tr. Vol. 1 at 67:3-11; 76:6-18 (Paul); Tr. Vol. 2 at 201:5-8 (Sheehan); Tr. Vol. 3 at 421:12-18 (Doe); Tr. Vol. 5 at 822:20-823:12 (Westhoff); Tr. Vol. 11 at 1783:15-1786:3 (Chasen). Moreover, as noted by the Third Circuit, "because a fetus may be 'living' as early as seven weeks lmp, use of the term 'living' instead of 'viable' indicates that, contrary to the understanding of the public and the concomitant rhetoric, the Act is in no way limited to late-term, or even mid-term, abortions." *Farmer*, 220 F.3d at 137 (holding state partial-birth abortion ban unconstitutionally vague, asserting that "the term 'living human fetus' adds little to the Act's constitutional certainty because it does not draw the line at viability, as the Supreme Court has done").

Nor does the requirement of an "overt act" sufficiently narrow the scope of the Act to give notice of the type of abortion procedure prohibited. Again, as set forth above in the court's findings regarding undue burden, the "overt act" may be interpreted to comprise many acts, performed not only in the process of an intact D & E, but in the course of a D & E by disarticulation or induction as well, including disarticulation of

the calvarium, cutting the umbilical cord, or compressing or decompressing the skull or abdomen or other fetal part that is obstructing completion of the uterine evacuation. Tr. Vol. 1 at 61:7-15; 70:1-6; 78:25-79:5 (Paul); Tr. Vol. 2 at 193:5-24; 205:8-15 (Sheehan); Tr. Vol. 3 at 405:13-22 (Doe); Tr. Vol. 4 at 523:1-524:1 (Broekhuizen); Tr. Vol. 11 at 1783:15-1786:3 (Chasen). Accordingly, the term "overt act" cuts such a wide swath that it cannot possibly be considered sufficient to put physicians on notice of what type of "overt" act violates the Act.

This court further concludes that the Act's vagueness and unconstitutional breadth cannot be cured by the alleged scienter requirements. First, the requirement that the physician "knowingly perform" a "partial-birth abortion," as defined by the Act, is of no help to the government. As plaintiffs have argued and the trial evidence has demonstrated, as part of their routine medical practice, a physician performing a D & E, by disarticulation or intact, or an induction abortion in the safest, most medically appropriate manner, "knows" that the procedure may proceed in such a manner that the physician may have to engage in procedures proscribed by the Act. *See* Tr. Vol. 1 at 74:14-80:20 (Paul); Tr. Vol. 1 at 165:7-21 (Sheehan); Tr. Vol. 2 at 281:15-21 (Drey); Tr. Vol. 3 at 420:9-22 (Doe); Tr. Vol. 4 at 550:18-552:9 (Broekhuizen); Tr. Vol. 4 at 657:3-8 (Creinin); Tr. Vol. 5 at 822:9-824:2 (Westhoff); Tr. Vol. 11 at 1783:15-1786:3 (Chasen).

Nor can the fact that the Act requires that a physician "deliberately and intentionally vaginally deliver a living fetus" cure the unconstitutional vagueness. The parties dispute whether the phrase modifies only the vaginal delivery or the additional steps contained in the

Act's definition of "partial-birth abortion." However, this court need not resolve that dispute, because, as the Third Circuit held in *Farmer*, this scienter requirement does nothing to ameliorate the vagueness of Act. *See Farmer*, 220 F.3d at 138 (rejecting state's argument that scienter requirement specifying "deliberate[] and intentional[] deliver[y] into the vagina of a living fetus" cured unconstitutional vagueness).

> At a minimum, to limit the scope of a statute to 'deliberately and intentionally' performing a certain procedure, the procedure itself must be identified or readily susceptible of identification. Here it is not.

Id. (citations omitted); *see also Planned Parenthood of Greater Iowa, Inc. v. Miller*, 195 F.3d 386, 389 (8th Cir. 1999) (Iowa partial-birth abortion ban's inclusion of scienter requirement did not save Act because Act still "encompasse[d] more than just the [intact D & E] procedure").

This same analysis applies to the Act's requirement that the procedure be "for the purpose" of performing "an overt act that the [physician] knows will kill the partially delivered fetus." Insofar as the court has already concluded that the Act's definition may encompass many second trimester abortions and that the terms "partial-birth abortion" and "overt act" are ambiguous, the inclusion of a scienter requirement cannot cure the vagueness and save the Act.

As noted previously, the government also argues that this court should narrow the construction of the statute to eliminate any doubts about the Act's unconstitutionality. This court rejects that argument for the reasons set forth above in the court's conclusions of law regarding the undue burden posed by the Act.

Accordingly, the court finds that the Act is unconstitutional on this ground as well.

IV. *HEALTH EXCEPTION*

Separate and apart from the undue burden and vagueness analyses, *Stenberg* also holds that "where substantial medical authority supports the proposition that banning a particular abortion procedure could endanger women's health, *Casey* requires the statute to include a health exception where the procedure is 'necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.'" *Stenberg*, 530 U.S. at 938, 120 S. Ct. 2597 (citing *Casey*, 505 U.S. at 879, 112 S. Ct. 2791). The Act, by contrast, excepts only "a partial-birth abortion that is necessary to save the *life* of a mother," and omits the health exception and the "appropriate medical judgment" requirements of *Casey* and *Stenberg*.

Although the court has already found that the Act is unconstitutional because it poses an undue burden and because it is vague, given the time and resources expended by the parties and this court, and the extensive evidence presented on the issue, the court is compelled to reach the issue regarding a health exception.

A. Parties' Arguments

Plaintiffs contend that *Stenberg* requires a health—not just life—exception under the circumstances, and that the congressional findings on the issue are not entitled to any deference. In support, plaintiffs assert that the intact D & E procedure, is a safe, if not a safer, option for pregnancy termination than other abortion procedures, and is necessary to preserve the health of certain women under certain circumstances. Additionally, plaintiffs also argue that the Act's life exception is

constitutionally inadequate because it does not allow a physician to determine, in his or her best medical judgment, whether the intact D & E procedure is necessary to preserve a woman's life.

The government, however, argues that the Act's life exception is constitutionally adequate because Congress has concluded that the procedure is never medically necessary, and that this court must defer to Congress' finding. The government, therefore, contends that the evidence before this court is relevant *only* in determining the degree of deference afforded Congress' finding regarding the necessity of a health exception.

B. Trial Evidence

At the outset, this court recognizes that Congress has made a finding pertinent to the trial evidence before this court, and that in affording the appropriate level of deference to Congress' finding, the evidence before this court may play a limited role in resolution of this issue. Nevertheless, the court, prior to determining the degree of deference to be accorded the congressional findings, summarizes in significant detail and finds as follows regarding the extensive evidence presented by both parties before this court.

1. Witnesses' Background and Qualifications

a. Plaintiffs' Witnesses

Plaintiffs presented trial testimony from eight expert witnesses in opposition to the Act, several of whom also provided testimony in the New York case. Plaintiffs' testifying experts included: Drs. Maureen Paul, Katharine Sheehan, Carolyn Westhoff, Fredrik Broek-

huizen, John Doe, Mitchell Creinin, Eleanor Drey, and Stephen Chasen.[16]

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[16] The court briefly sets forth the qualifications of each of plaintiffs' testifying experts. Dr. Maureen Paul is a board-certified obstetrician and gynecologist ("obgyn") who also holds a masters' degree in public health and epidemiology (the study of research methods in determining what groups are affected by what diseases). Dr. Paul serves as the chief medical officer for plaintiff Planned Parenthood Golden Gate and is an associate clinical professor at the University of California San Francisco ("UCSF"). She is also the editor-in-chief of the leading textbook on abortion procedure. Dr. Paul has never previously testified as an expert witness in any abortion-related case. *See* Exh. 60 (Paul CV); Tr. Vol. 1 at 6:13-13:-23.

Likewise, Dr. Katharine Sheehan is a board-certified obgyn who serves as the full-time medical director of the Planned Parenthood affiliate for San Diego and Riverside Counties, which is the only provider of second trimester abortions beyond 18 weeks for the entire area of California south of Los Angeles. She also has a private practice and teaches as a clinical faculty member of the University of California San Diego ("UCSD") medical school. She has never testified in any court cases previously. Exh. 66 (Sheehan CV); Tr. Vol. 1 at 151:6-164:5:3, Tr. Vol. 2 at 178:8-179:8 (Sheehan).

Dr. Doe testified in this case under a pseudonym. He is a board-certified obgyn who is board eligible in maternal-fetal medicine. He practices in the San Francisco Bay Area. He has never given testimony in court before. Tr. Vol. 3 at 377:8-387:23 (Doe).

Dr. Fredrik Broekhuizen is a board-certified obgyn who serves as a part-time medical director or Planned Parenthood of Wisconsin, a full professor of obstetrics at the Medical College of Wisconsin, and who also has a private practice. He has previously testified in other abortion litigation. Exh. 6 (Broekhuizen CV), Tr. Vol. 4 at 481:12-494:11 (Broekhuizen).

Dr. Mitchell Creinin is a board-certified obgyn. He is a full professor of obstetrics and epidemiology at the University of Pittsburgh, and the part-time medical director of that area's Planned Parenthood affiliate. He is also the co-author of a chapter in a

Plaintiffs' expert witnesses all currently practice and/or teach in the area of obstetrics and gynecology ("obgyn"), and all were qualified as experts in that area and in abortion practice. Additionally, three of the eight were also qualified as experts in maternal-fetal medicine; two were qualified as experts in epidemiology; and one taught epidemiology jointly with his medical practice. All eight have performed intact D & Es during the course of their practices, with varying frequencies, and all of those experts who teach in the area of abortion practice teach the intact D & E variant. Of plaintiffs' witnesses asked to quantify the number of abortions they had performed, all answered in the thousands. *See, e.g.*, Tr. Vol. 1 at 160:5-14 (Sheehan, estimating 30,000); Tr. Vol. 5 at 732:10-12 (Creinin,

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leading obstetrics textbook on induction abortions. Exh. 28 (Creinin CV), Tr. Vol. 4 at 645:13-656:20 (Creinin).

Dr. Carolyn Westhoff is a board-certified obgyn who is affiliated with the New York Presbyterian Hospital and is a professor at the Columbia University Medical School in both obgyn and epidemiology. She is a member of the board of Planned Parenthood, is a member of the National Abortion Federation ("NAF") and has provided testimony in a number of cases involving Planned Parenthood. Exh. 67 (Westhoff CV), Tr. Vol. 5 at 790:240-798:10, 834:1-835:21 (Westhoff).

Dr. Eleanor Drey is a board-certified obgyn, the medical director of the Women's Option Center at San Francisco General Hospital, and an assistant clinical professor teaching abortion methods at UCSF. She has never offered expert testimony before. Tr. Vol. 2 at 274:9-278:2, 286:15-291:3 (Drey), Exh. 33 (Drey C.V.).

Dr. Stephen Chasen is board-certified in both obgyn and maternal-fetal medicine. He is an associate professor at the Cornell University Medical Collee and directs the high-risk obstetrics program, the obgyn residency program, and the maternal-fetal medicine fellowship program. Exh. 24 (Chasen CV), Tr. Vol. 11 at 1705:12-1717:19 (Chasen).

estimating 5,000). Moreover, all eight opine that enforcement of the Act would significantly affect their patients and practices, and could subject them to prosecution under the Act. Six of plaintiffs' experts have never previously testified in any case involving a ban on abortion. None of plaintiffs' experts testified before or was consulted by Congress with respect to the drafting of the Act or the findings supporting the Act.[17]

Plaintiffs also submitted the deposition testimony of five experts: one who is an expert in perinatal and gynecological pathology, and four of whom are experts in obgyn and abortion practice, including intact D & E. Three of the four are also experts in maternal-fetal medicine.

b. Government Witnesses

The government presented trial testimony from five expert witnesses. Several of these witnesses practice and teach in obgyn; and four of the five were, therefore qualified as experts in that area. Two of those four were also qualified as experts in maternal-fetal medicine, and one was qualified as an expert in medical literature. Three of the four were qualified as experts in pregnancy termination. However, none had performed the intact D & E procedure at issue in this case. Moreover, none had been instructed regarding the procedure or had personally observed the procedure being performed.

All four witnesses had testified previously in support of state law restrictions on abortion, or had offered testimony before Congress in support of the Act, or

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[17] One of plaintiffs' witnesses, Dr. Creinin, wrote a letter to Congress in opposition to the Act.

both. The government's fifth testifying expert, Dr. Anand, was qualified as an expert in the areas of pharmacology of anesthetic drugs, fetal neurobiology, and fetal pain.

The government also introduced deposition testimony from one expert witness, an expert in obgyn, maternal-fetal medicine, and abortion practice, with the caveat that he has never performed an intact D & E procedure.

The four government witnesses qualified as experts in obgyn included Drs. Leroy Sprang, Curtis Cook, Watson Bowes, and Elizabeth Shadigian.

Dr. Sprang, an associate clinical professor at Northwestern University and a practicing obgyn for approximately twenty eight years, testified that he had never performed any abortion procedure on a fetus post-17 weeks lmp, that he had performed fewer than twenty D & Es by disarticulation in his twenty eight years of practice, all of which were on demised fetuses, and that he had never been instructed regarding, had never taught, performed, or even observed an intact D & E procedure. Tr. Vol. 7 at 1033:17-18; 1034:1-1038:4 (Sprang). He further testified that his knowledge regarding intact D & E was based exclusively on his conversations with other physicians,[18] his review of

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[18] Dr. Sprang testified that his knowledge regarding the intact D & E procedure was derived from conversations with other physicians. *Id.* at 1041:1-1046:6. He claimed that there were two "significant" or "memorable" physicians with whom he had discussions after a meeting, and had received more information than usual regarding the intact D & E procedure. *Id.* at 1042:20-22. However, he could not recall the names, dates, or locations associated with those conversations. *Id.* at 1044:4-14.

medical literature, and his involvement in this litigation and other litigation in which he was required to read other expert reports and related documents. *Id.* at 1045:2-1052:4. The court also notes that Dr. Sprang has never conducted clinical research in the area of abortion. *Id.* at 1029:3-7.

Like Dr. Sprang, while Dr. Cook possesses expertise generally in obgyn and maternal-fetal medicine, he also lacks expertise regarding the intact D & E procedure in particular. Dr. Cook has never performed, personally observed, supervised, received instruction in, or taught the intact D & E procedure.[19] Tr. Vol. 9 at 1380:7-1381:7 (Cook). Dr. Cook also lacks expertise in post-20 week D & Es generally. *Id.* at 1365:15-22. He has performed only three to five D & Es by disarticulation in his career, limited to cases where fetal demise had already occurred. *Id.* at 1364:14-25. Moreover, in terms of his observation of D & Es by disarticulation, Dr. Cook testified that he generally observes the procedure prior to 18 weeks gestation. *Id.*

Moreover, this basis for Dr. Sprang's knowledge is somewhat questionable since two of plaintiffs' witnesses in this case, Drs. Hammond and Frederiksen, teach at Northwestern as well. While he was aware that Dr. Hammond teaches intact D & E at Northwestern, Dr. Sprang testified that he was aware of the practices and teachings of Drs. Hammond and Frederiksen only from the residents at Northwestern because he had never spoken with either of them in person. *Id.* at 1046:3-6. Moreover, although she is on the faculty at his university, he knows Dr. Frederiksen "very minimally" and "if [he] saw her in the room, [he] wouldn't be sure that [he] would recognize her." *Id.* at 1166:1-21.

[19] Dr. Cook did testify that he once observed a videotape of the evacuation process of an intact D & E; however, the quality of the videotape was extremely poor.

The same is true of Dr. Bowes, an emeritus professor of obgyn at the University of North Carolina/Chapel Hill, retired from his clinical practice. He is board-certified in obgyn and maternal-fetal medicine. Tr. Vol. 6 at 875:1-879:7 (Bowes). Dr. Bowes has never performed an intact D & E; and he has only performed 2-3 D & Es by disarticulation on fetuses that had not already died at the time of the procedure. *Id.* at 978:8-983:23. Those D & Es were performed to save the mother's life, as Dr. Bowes believes that abortion generally is warranted only when there are severe medical complications that threaten a mother's life. *Id.* at 977:1-4.

Likewise, Dr. Elizabeth Shadigian, an obgyn and a clinical associate professor of obgyn at the University of Michigan, testified that she has never performed an intact D & E, and has never supervised, observed, been instructed in, or taught the procedure. Tr. Vol. 8 at 1214:3-1215:3 (Shadigian).[20] Of the abortions that she has performed on fetuses prior to demise, all have been

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[20] She further attested that she probably did not even personally know any physicians who performed the procedure, and had never done any research regarding the procedure other than in connection with the instant litigation. *Id.* at 1214:22-1215:6. Dr. Shadigian testified that she was not aware of the intact D & E procedure being taught at the University of Michigan, where she works. *Id.* at 1231:12-1232:7. However, she did testify that she was aware that the chair of the Maternal-Fetal Medicine Department at the University of Michigan, Dr. Timothy Johnson, whom she testified she respected as a physician, was of the opinion that intact D & E was the safest and most appropriate procedure under certain circumstances and that she had no reason to doubt Dr. Johnson's testimony in the New York case that such procedures are conducted up to 22 wks lmp at the University of Michigan. *Id.* at 1294:20-1297:4; 1316:19-25.

induction abortions under circumstances of severe maternal complications. In her career, all of the D & Es by disarticulation that she has performed have been on demised fetuses.

c. Expert Qualifications

Accordingly, this court found that the government's experts lacked the background, experience, and instruction to qualify as experts regarding the technique of the intact D & E procedure. Instead, the court allowed the government's experts to testify only regarding their opinions on the safety of the procedure, based upon their review of the literature. The court noted that if it were to qualify the government's witnesses, who did not "appear to have any personal experience with late-term abortion procedures at issue here," it would mean that any obgyn would be considered an expert on late-term abortions. *See* Tr. Vol. 7 at 1052:22-25.

Overall, while the government's witnesses are eminently qualified as obgyn practitioners, the court finds that the government's witnesses lack the qualifications, experience, and knowledge possessed by plaintiffs' witnesses with respect to late-term abortion procedures generally, and intact D & E in particular.

2. Overview of Plaintiffs' Evidence

Plaintiffs presented evidence that intact D & E is at least as safe as D & E by disarticulation, and under some circumstances safer, because the procedure is quicker and requires fewer passes with the forceps. Plaintiffs also presented evidence that common sense and sound medical judgment indicate that fewer passes reduce the risk of uterine perforation and cervical lacerations from instruments and/or fetal bone fragments. Tr. Vol. 1 at 70:10-17 (Paul); Tr. Vol. 1 at 166:13-167:2,

169:7-13, Tr. Vol. 2 at 186:14-187:16 (Sheehan); Tr. Vol. 3 at 399:18-400:217, 407:12-20 (Doe); Tr. Vol. 5 at 798:12-804:5 (Westhoff); Tr. Vol. 11 at 1755:5-1756:19 (Chasen). Certain of defendants' witnesses agreed. Tr. Vol. 6 at 944:20-945:21 (Bowes); Tr. Vol. 8 at 1285:4-14 (Shadigian); Tr. Vol. 9 at 1486:11-1487:5 (Cook). *But see* Tr. Vol. 7 at 1127:8-1128:12 (Sprang, opining that no risk in additional passes if ultrasound is used).

In addition, since the fetus undergoes less disarticulation, the risk of leaving fetal parts in the uterus is diminished, and the procedure is likely to take less time. Tr. Vol. 1 at 72:7-73:8 (Paul); Tr. Vol. 5 at 799:1-4, 800:13-4, 801:8-21 (Westhoff). The quicker the procedure, the less time the woman must spend under sedation, which further reduces the potential for complications caused by anesthesia. Tr. Vol. 1 at 168:19-169:6 (Sheehan). Plaintiffs also argue that a shorter surgical procedure will decrease the amount of blood loss and the risk of infection. Tr. Vol. 5 at 799:4 (Westhoff); Tr. Vol. 11 at 1756:15-19 (Chasen).

Because the intact D & E procedure results in a fetus that remains relatively intact after surgery, an autopsy of the fetus for diagnostic purposes is possible, particularly if the reason for the abortion was due to fetal anomalies. Such further diagnosis may be helpful for the woman in planning for future pregnancies. Tr. Vol. 2 at 189:3-20 (Sheehan); Tr. Vol. 11 at 1757:14-1758:19 (Chasen). Some women also prefer a surgical procedure that yields a relatively intact fetus for psychological reasons, so that the mother can hold the fetus and, if desired, have the fetus receive religious rites. *See, e.g.*, Tr. Vol. 4 at 503:18-504:3; 562:10-22 (Broekhuizen). However, if the intact D & E procedure destroys the contents of the brain, analysis of the brain tissue would

be impossible. Tr. Vol. 2 at 254:17-25 (Sheehan); Tr. Vol. 3 at 433:9-434:6 (Doe, also noting that brain tissue is not always needed in autopsies and cannot always be successfully obtained even in inductions).

The AMA task force, on which government witness Dr. Sprang served, concluded that intact D & E "may minimize trauma to the woman's uterus, cervix, and other vital organs, [and] may be preferred by some physicians, particularly when the fetus has been diagnosed with hydrocephaly or other anomalies incompatible with life outside the womb." Tr. Vol. 7 at 1133:12-1134:8 (Sprang).

3. Overview of Government's Evidence

In contrast, the government took the position that intact D & E is a dangerous procedure that is less safe than any other second trimester abortion method, is never medically necessary, and could potentially pose grave risks to women's health. The government argues that not only is there no scientific evidence showing that the procedure is safe as a whole, but the individual elements of the procedure have been shown to be unsafe as well. *See, e.g.*, Tr. Vol. 7 at 1079:1-1081:5 (Sprang); Tr. Vol. 8 at 1233:12-1234:3 (Shadigian); Tr. Vol. 9 at 1411:22-1416:1 (Cook).

The government also introduced evidence that in no situation is an intact D & E medically necessary, since a woman could always undergo another method of second trimester abortion in any given situation, including D & E by disarticulation, induction, or hysterotomy or hysterectomy. *See, e.g.*, Tr. Vol. 7 at 1110:14-1111:9 (Sprang); Tr. Vol. 8 at 1220:16-21 (Shadigian); Tr. Vol. 9 at 1390:3-22 (Cook).

4. Medical Organizations

Numerous medical organizations are divided on their positions regarding the Act. Among the largest organizations that oppose the Act are ACOG, a professional membership organization organized in 1951, concerned with professional practice and education in the health care of women. ACOG has more than 44,000 members in the United States, Canada, and Mexico. Each member of ACOG is a board-certified obgyn, and more than 90% of all board-certified obgyns are members of ACOG. *See generally* Deposition of Joanna Cain, M.D. ("Cain Depo").

The California Medical Association ("CMA") also opposes the Act. The CMA, which advocates for the interests of physicians and their patients, is California's largest medical association, with more than 30,000 members, comprised of licensed physicians. *See generally* Deposition of John Whitelaw, M.D. ("Whitelaw Depo"). Two other associations, the American Medical Women's Association ("AMWA"), an organization of 10,000 medical professionals, including women physicians, residents, and medical students, dedicated to advancing women in medicine and improving women's health, and the American Public Health Association ("APHA"), an organization with approximately 50,000 members from all public health occupations, including obstetricians and gynecologists, devoted to advancing and promoting public health, also oppose the Act. *See generally* Deposition of Meghan Kissell ("Kissell Depo"); Deposition of Alan Baker ("Baker Depo").

Among those organizations that supported the Act were the Association of American Physicians & Surgeons ("AAPS"), which submitted an amicus brief in support of Nebraska in the *Stenberg* case. AAPS is a

nonprofit organization dedicated to defending the practice of private medicine. It submitted the amicus brief on behalf of several other medical organizations, including ISMS, the Illinois State Medical Society. An organization co-founded by government witness Dr. Cook to advocate for the banning of partial-birth abortion, the Physicians' Ad Hoc Coalition for Truth ("PHACT"), with approximately 400 physician members, also opposed the Act. *See* Tr. Vol. 9 at 1361:11-62:14 (Cook).[21]

The American Medical Association ("AMA"), a national association with approximately 250,000 physician and medical student members, created to advocate on behalf of physicians and patient rights, supported the Act initially, but subsequently withdrew its support because of the criminal penalties included in the Act.

5. Scientific Studies on Intact D & E

The parties agree that no definitive large-scale studies have been completed that conclusively show that intact D & E is safe, or that it is unsafe. Tr. Vol. 1 at 102:9-14 (Paul); Tr. Vol. 3 at 438:5-11, 443:3-9 (Doe); Tr. Vol. 5 at 849:9-12 (Westhoff); Tr. Vol. 6 at 905:19-909:20, 971:14-972:19 (Bowes); Tr. Vol. 8 at 1297:25-1298:12 (Shadigian).

It is the government's position that in the absence of definitive studies concluding that intact D & E is safe, physicians should not be permitted to use the technique. *See, e.g.*, Tr. Vol. 8 at 1221:5-12, 1229:2-6, 1232:8-13 (Shadigian). Plaintiffs, on the other hand, take the position that in the absence of studies concluding that intact D & E is unsafe, physicians should be able to

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[21] PHACT, however, is no longer in existence.

exercise their own medical judgment to determine if the procedure is appropriate under the circumstances presented. *See, e.g.*, Tr. Vol. 1 at 90:13-17 (Paul); Tr. Vol. 11 at 1828:3-21 (Chasen).

a. Research Methodology

The medical community follows certain epidemiological principles when evaluating the weight and significance of research results, and all parties recognized these principles in presenting trial evidence.

In general, "evidence-based medicine is a way of doing medicine that takes into consideration the scientific information that is available. . . . [I]f there is good evidence that one particular method should be used, then it is [the physician's] responsibility to use that method, but where that evidence is lacking or inadequate, then we use our best clinical judgment to render the safest care possible for our patients." Tr. Vol. 1, 91:5-13 (Paul).

Research methodology is evaluated on a hierarchy. Prospective randomized trials, where patients are selected before any treatment begins and randomly placed into treatment groups, yield the most significant results, since this type of study is considered to be subject to the least amount of bias. The next most reliable study is a retrospective cohort study, where records are reviewed after patients have undergone different types of treatment and the results are compared. Somewhat less reliable is a retrospective case study series, where records are reviewed after patients have undergone one specific type of treatment and the results are reported. Finally, if there is no study possible or available, doctors should rely on their clinical judgment and experience in determining what medical

methods to use. Tr. Vol. 1 at 95:17-97:21 (Paul); Tr. Vol. 2 at 253:3-254:2 (Sheehan); Tr. Vol. 2 at 346:13-348:15 (Drey); Tr. Vol. 6 at 890:15-894:7, 895:25-896:8 (Bowes); *cf.* Tr. Vol. 8 at 1298:13-1299:3 (Shadigian, stating that intuitive judgment is of no value in assessing short-and long-term risks). When studies have been conducted, doctors are encouraged to incorporate the results into their practice.[22]

Certain published studies are also subjected to peer review, where other doctors practicing in the same area will review results and provide criticism and commentary designed to ensure the accuracy of the results reported. Tr. Vol. 1 at 97:22-98:6 (Paul); Tr. Vol. 6 at 894:8-895:4 (Bowes).

b. Studies on Abortion Safety

The parties agree that abortion in general is a safe procedure, and that it is in fact safer than carrying a pregnancy to term. Tr. Vol. 1 at 22:11-38:5 (Paul, noting that risk of death from childbirth is 10 times greater than risk of death in abortion). The parties also agree that while no published studies comparing the safety of intact D & E to other methods of abortion exist, various studies have examined individual aspects of the intact

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[22] While the government argues that studies have shown that other clinical procedures previously believed to be safe as a matter of clinical judgment, such as episiotomies (surgical incisions in the vagina during childbirth) or fetal heart monitoring, are in fact detrimental to either the woman or the fetus, *see, e.g.*, Tr. Vol. 1 at 103:23-105:7, 109:20 (Paul); Tr. Vol. 3 at 439:22-441:2 (Doe); Tr. Vol. 6 at 896:9-897:24 (Bowes), the government also concedes that those studies would not support a ban on these procedures if used in a physician's best judgment. Tr. Vol. 6 at 972:20-974:15 (Bowes); Tr. Vol. 8 at 1301:12-21 (Shadigian).

D & E procedure, and others have compared the safety of D & Es generally with other methods of abortion.

The first large-scale studies on abortion safety took place in the 1970s, through the Joint Program for the Study of Abortion ("JPSA"), administered through the Centers for Disease Control ("CDC"). The JPSA study ran from 1971-1979, and included over 250,000 women.[23] It concluded that D & E abortions led to significantly fewer major medical complications than inductions, which at that time were performed using saline injections.[24] Tr. Vol. 1 at 25:18-31:13 (Paul).

The parties agree that the methods of performing both D & E and induction abortions have changed since the time the JPSA studies were conducted, and both procedures have become even more safe. Tr. Vol. 1 at 31:14-19 (Paul). Individual witnesses, though, disagree as to which method between the two is better. *Compare, e.g.*, Tr. Vol. 5 at 717:24-719:3 (Creinin, noting that while inductions are safe, they have not improved in safety over the last 20 years); Tr. Vol. 3 at 414:8-14 (Doe, noting anecdotally that inductions have more complications than D & Es); Tr. Vol. 11 at 1771:22-1772:19 (Chasen, stating that D & Es are still significantly safer than current induction methods); Tr. Vol. 6 at 946:5-13 (Bowes, agreeing D & E safer than induction) *with* Tr. Vol. 7 at 1092:17-1093:7, 1122:14-1123:5 (Sprang, claiming inductions as safe or safer than D &

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[23] The JPSA program no longer exists. Tr. Vol. 1 at 31:20-32:1.

[24] While data regarding intact D & E was not broken out separately, plaintiffs argue that at least some of the safety data included in the JPSA study would have included intact D & Es, since intact D & Es are merely a variant of D & Es in general. Tr. Vol. 1 at 48:18-23 (Paul).

E); Tr. Vol. 8 at 1229:2-6, 1269:15-1274:25 (Shadigian, claiming inductions unambiguously safer than D & E).

In terms of abortion mortality, the primary study relied upon is based on data collected by the CDC between 1972-1987, and includes information about abortion-related deaths throughout the United States. Exh. 63 (Lawson report). That study concluded that while the risk of death increases with fetal gestational age, the risks of mortality from D & E are very low, and comparable to those for induction. Most of the witnesses agreed that both of those procedures are also significantly safer than a hysterectomy or hysterotomy. Exh. 63 (table III; listing D & E as "evacuation," and induction as "instillation"). *See also* Tr. Vol. 1 at 32:7-37:7, 82:13-85:11 (Paul); Tr. Vol. 3 at 414:15-415:23 (Doe) (noting risks of hysterotomy and hysterectomy). *But see* Tr. Vol. 9 at 1517:2-11 (Cook, recommending hysterotomy over D & E).

c. Lack of Published Studies on Intact D & E

The JPSA and CDC studies provide the latest available statistics from long-term and large-scale studies on abortion safety comparing D & E to induction. The parties agree that relatively few studies have been conducted on second trimester abortions generally, and none have been published on the subject of intact D & E. *See, e.g.*, Tr. Vol. 5 at 719:19-720:3 (Creinin); Tr. Vol. 6 at 905:19-908:20 (Bowes). Furthermore, the few studies that have been published have not been on the same scale or held the same authoritative value as the JPSA and CDC results.[25]

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[25] One study, by Dr. Amy Autry, published in 2001 in the American Journal of Obstetrics and Gynecology, concluded that modern methods of induction had a higher rate of complication

Because there is no significant authoritative data about intact D & E, while extensive authoritative data about the safety of other methods of second trimester abortion exists, the government presented evidence that physicians have a responsibility to use those other methods until such time that intact D & E is proven to be safe. *See, e.g.*, Tr. Vol. 6 at 922:20-924:6 (Bowes); Tr. Vol. 8 at 1237:3-1239:18, 1257:9-1258:12 (Shadigian).

Plaintiffs, on the other hand, presented evidence that the study of abortion poses various methodological difficulties. As an initial matter, since abortion is so safe in general, a large number of women would need to be included in any study to make any meaningful findings on safety. Furthermore, since so few women have second trimester abortions, a large number of institutions would be required to participate in any study to ensure that sufficient numbers of women could be included. *See* Tr. Vol. 1 at 89:4-90:11 (Paul); Tr. Vol. 5 at 705:4-707:19 (Creinin, noting that any study would require over 5000 women in each group to be statisti-

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than modern methods of D & E. Tr. Vol. 1 at 85:16-86:7 (Paul); Tr. Vol. 5 at 719:19-722:2 (Creinin). However, the study was relatively small, had some methodological problems, and the parties dispute whether the main complication seen (retained placenta) should properly be considered a "complication" of induction. *Compare* Tr. Vol. 1 at 114:3-115:13 (Paul); Tr. Vol. 5 at 776:16-777:19 (Creinin) *with* Tr. Vol. 7 at 1094:9-1099:9 (Sprang); Tr. Vol. 8 at 1278:13-1281:15 (Shadigian); Tr. Vol. 9 at 1394:13-1395:19 (Cook). Another study on modern methods of second trimester abortion, by Dr. David Grimes, was attempted but could not be completed because researchers could not obtain sufficiently high numbers of women consenting to an induction to make the numbers statistically significant. Tr. Vol. 5 at 707:24-709:24 (Creinin); Tr. Vol. 6 at 932:20-938:18, 951:8-954:9 (Bowes, concluding that study would be difficult but not impossible to perform).

cally significant). Plaintiffs note that it is also very difficult to secure sufficient funding or cooperation for studies relating to abortion funding, given the controversial nature of the subject.[26] Tr. Vol. 5 at 780:8-13 (Creinin).

Even if women who are willing to participate in studies can be located, there are further problems related to obtaining their consent. Many women have strong preferences as to which abortion procedures they wish to undergo, and thus it is difficult to achieve consent for true randomization of abortion methods, as would be required to conduct a full prospective study. Tr. Vol. 5 at 703:19-709:24 (Creinin). More significantly, because doctors cannot tell whether an intact D & E is feasible until the procedure has begun, it is difficult to control the number of procedures included in the studies. Tr. Vol. 3 at 441:22-442:9 (Doe). Under these circumstances, plaintiffs conclude that the principles of evidence-based medicine permit doctors to continue performing intact D & Es in their best medical judg-

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[26] Because of this distinction, the government's use of the studies published in the *Lancet* journal on breech deliveries as a comparator is unpersuasive. *See, e.g.*, Tr. Vol. 6 at 924:9-925:10 (Bowes). While breech deliveries are rare, they are not as rare as second trimester abortions, they occur worldwide, and they are not associated with political controversy. To obtain a statistically significant sample size, the studies done of breech deliveries involved 121 different hospital centers located in 26 different countries. Additionally, breech deliveries are performed in standard ways. Tr. Vol. 5 at 778:22-779:22 (Creinin); Tr. Vol. 6 at 955:10-956:21 (Bowes); Tr. Vol. 8 at 1299:14-1301:21 (Shadigian). Given the nature of abortion practice and policy, it would be extremely difficult to obtain a similar level of support for studies of the intact D & E procedure.

ment, even in the absence of studies on the topic. Tr. Vol. 1 at 90:13-17 (Paul).

d. Chasen Study

While there are no published studies on the safety of intact D & E, one study by Dr. Stephen Chasen comparing modern methods of intact D & E with D & E by disarticulation is currently in press. Exh. 19.[27] The parties strongly dispute the interpretation of Dr. Chasen's findings.

i. Methodology and Results of Study

Dr. Chasen conducted a retrospective cohort study examining the medical records of 383 women who had second trimester abortions after 20 weeks of pregnancy at the Cornell Weill Medical Center from 1996 to June 2003. Of those women, 120 underwent an intact D & E, and 282 underwent a D & E by disarticulation.[28] Exh. 29. *See generally* Exh. 29, Tr. Vol. 11 at 1735:1-1754:17 (Chasen); *see also* Vol. 5 at 805:16-811:17, 850:22-864:17 (Westhoff).

The fetuses of the women who underwent an intact D & E were at a median of 23 weeks gestation, which was two weeks more advanced than the median gestational age of the fetuses of the women who underwent a D & E by disarticulation (21 weeks). The median blood loss suffered by each group was identical (100 mL), and the median procedure time was identical as well (22 minutes). The blood loss for the D & E by disarticulation

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[27] The article is scheduled for publication in May 2004 in the American Journal of Obstetrics and Gynecology, by Elsevier.

[28] The article refers to intact D & E as "intact D & X," and D & E by disarticulation as "D & E." Intact D & E in the article is defined as any extraction where forceps were not needed to disarticulate the fetus.

group ranged from 40 mL to 1500 mL, and the procedure time ranged from 6-60 minutes. The blood loss for the intact D & E group ranged from 20 mL to 1200 mL, and the procedure time ranged from 6-45 minutes. Exh. 29.

Of the 383 women, 19 suffered complications, with equal frequency in both groups. However, the six complications observed in the intact D & E group were considered relatively minor (4 superficial lacerations and 2 follow-up curettages), and none were major (defined as requiring admission to an intensive care unit). In the group undergoing D & E by disarticulation, most injuries were minor, but three major complications occurred: one amniotic fluid embolus, where amniotic fluid is introduced into the woman's bloodstream; one case of sepsis, or generalized infection throughout the woman's system; and one perforated uterus. Exh. 29. Both parties concede that these complications are generally very rare, and that these results thus cannot be given much weight. Tr. Vol. 11 at 1746:9-1747:10 (Chasen); Tr. Vol. 7 at 1104:7-1105:18 (Sprang).

The study also followed 62 of these women into subsequent pregnancies, when they obtained their prenatal care at the Cornell Medical Center. Of these 62 women, only 4 experienced preterm birth, 2 who had undergone a D & E by disarticulation and 2 who had undergone an intact D & E. The two women who had undergone intact D & E and subsequently experienced early labor were both previously considered at high risk for premature labor, and were able to continue their subsequent pregnancies significantly longer than their previous ones. Tr. Vol. 5 at 810:21-24 (Westhoff); Tr. Vol. 11 at 1749:16-1751:17 (Chasen).

The article concludes that intact D & E and D & E by disarticulation are equally safe procedures, and that the decision of which technique to use should be left to the performing physician's medical judgment. The article also concludes that intact D & E does not appear to have adverse effects on maternal health. Exh. 29.

ii. The Parties' Interpretations of the Chasen Study

Plaintiffs interpret this study as indicating not only that intact D & E is safe, but that it is in fact safer than D & E by disarticulation. For instance, the women undergoing intact D & E had more advanced pregnancies, which normally would indicate a higher likelihood of complications, since abortions become more difficult to perform as gestational age increases. However, the complication rates were identical for intact D & Es at 23 weeks gestational age and D & Es by disarticulation at 21 weeks gestational age, which plaintiffs argue permits the inference that the intact D & E is in fact safer than D & E by disarticulation. Tr. Vol. 5 at 808:11-810:9 (Westhoff); Tr. Vol. 11 at 1747:11-1748:18 (Chasen); *see also* Tr. Vol. 6 at 945:22-946:4 (government witness Bowes, agreeing).

The government, in contrast, notes that any arguments concerning the increased safety of the intact D & E due to the shorter time of the procedure and smaller amounts of blood loss are contradicted by the findings which show that on average, an intact D & E takes exactly as much time as a D & E by disarticulation. Tr. Vol. 11 at 1807:2-1811:18 (Chasen, agreeing with these findings).

Plaintiffs emphasized that while the median blood loss and procedure times were identical for intact D & E and D & E by disarticulation, the maximum values

for these factors were significantly lower for the intact D & E group. This indicated to certain of plaintiffs' experts that the most difficult intact D & Es take less time and result in less blood loss than the most difficult D & E by disarticulation, and therefore they believed this indicated the greater safety of the intact D & E procedure. Tr. Vol. 5 at 860:20-862:13 (Westhoff).

The government presented evidence in response that the Chasen study, while useful as an initial study of intact D & E, was too small in scale to support any conclusions.[29] Tr. Vol. 6 at 915:20-920:25 (Bowes), Tr. Vol. 7 at 1101:8-1108:13 (Sprang). The government noted, for example, that after peer review of the article, Dr. Chasen agreed to add language noting that the study's retrospective nature and the relatively small sample size made it difficult to draw more generalized conclusions about the safety of the procedure. Tr. Vol. 11 at 1810:12-1814:18 (Chasen). This difficulty applies both to the findings as to safety, as well as to the findings on subsequent preterm labor, which the government notes is further flawed in that follow-up care could be reviewed only for patients who returned to the Cornell Medical Center. Tr. Vol. 11 at 1793:23-

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[29] The government also argued that Dr. Chasen, as a plaintiff in the New York litigation, was biased in favor of intact D & E, as seen by his failure to disclose to the journal publishers his plaintiff status or his previous participation in Planned Parenthood litigation. *See, e.g.*, Tr. Vol. 6 at 921:1-922:4 (Bowes). Dr. Chasen convincingly testified that he had fully complied with the publisher's ethical policy, and noted that the research for the article was completed before these lawsuits were filed. Tr. Vol. 11 at 1802:13-1806:11, 1825:3-1826:19 (Chasen). While Dr. Chasen's support of Planned Parenthood in previous litigation is noted, the court is not persuaded that Dr. Chasen acted unethically or that his research results are biased as a result of his outside activities.

1794:22 (Chasen, on cross); Tr. Vol. 6 at 919:12-25 (Bowes).

e. Risks of Intact D & E

The government argues that intact D & E is a dangerous procedure that is less safe than any other second trimester abortion method and that it poses grave risks to women's health. *See, e.g.*, Tr. Vol. 7 at 1079:1-1081:5 (Sprang). *But see* Tr. Vol. 6 at 974:21-976:7 (Bowes, stating that intact D & E does not appear to pose any long-term risks to women's health). Plaintiffs take a contrary position and refute the risks asserted by the government. These risks primarily include the following.

i. Cervical Incompetence

The government presented evidence that the use of 25-30 osmotic dilators could potentially overstretch the cervix and lead to a condition called "cervical incompetence," a condition where the cervix painlessly dilates during a subsequent pregnancy and causes either miscarriage or preterm delivery. Tr. Vol. 7 at 1081:14-1082:8 (Sprang); Tr. Vol. 9 at 1413:4-1415:5 (Cook). In support of this position, the government relies on an October 2001 study by Dr. Laurence Henriet published in the British Journal of Obstetrics and Gynaecology, which studied 12,000 women in France and concluded that abortion increased the risk of preterm delivery.

Plaintiffs dispute the methodology of the Henriet study as "awful," Tr. Vol. 5 at 755:25 (Creinin), noting that the study was purely retrospective and based on subjective self-reporting, which could have notably skewed the results, since women who experienced preterm delivery would be predisposed to recall previous abortions at a higher rate than those who did not (a

phenomenon known as "recall bias").[30] The study also was designed to compare women who had had abortions to women who had not had abortions. Plaintiffs presented evidence that these two groups are irrelevant to a study whose aim is to compare women who have undergone one method of abortion (intact D & E) with women who have undergone another method of abortion. Tr. Vol. 5 at 780:15-784:2 (Creinin); Tr. Vol. 9 at 1493:22-1496:25 (Cook).

Plaintiffs also question the relevance of the results to the issues at hand. For instance, 96% of the abortions reported in the study were performed in the first trimester. Data regarding those abortions does not relate to the question whether intact D & E abortions in the second trimester cause cervical incompetence, especially since most first trimester abortions do not involve the use of osmotic dilators or prostaglandin drugs but rather mechanical dilators, which are known to cause more trauma to the cervix. Plaintiffs also note that "preterm delivery" is different from "cervical incompetence," in that cervical incompetence can cause preterm delivery, but not all preterm deliveries are caused by cervical incompetence. Tr. Vol. 5 at 780:15-784:2 (Creinin); Tr. Vol. 7 at 1144:22-1147:7 (Sprang, on cross).

Plaintiffs cite instead a 2002 article by Dr. Robin Kalish from the American Journal of Obstetrics and Gynecology, which concluded that second trimester D & Es did not cause an increased risk of miscarriage or

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[30] Plaintiffs also note that the government's position makes no physiological sense, since the cervix is dilated much wider and in a much shorter period of time in both induction abortions and in childbirth at term. Tr. Vol. 4 at 691:15-692:2 (Creinin).

preterm birth. Exh. 17 (study co-authored by Chasen). This paper was a retrospective case series, which followed 96 women who subsequently became pregnant after a second trimester D & E. The paper also noted that increased cervical dilation in the D & E actually decreased the likelihood of miscarriage or preterm birth in the second trimester, theorizing that increased dilation reduced the risk of cervical trauma when removing the fetus. Tr. Vol. 11 at 1726:13-1735:2 (Chasen); *see also* Tr. Vol. 4 at 692:3-691:17 (Creinin testimony on study); Exh. 29 (Chasen study discussed above, similarly concluding no increased risk of preterm birth after intact D & E). *See also* Tr. Vol. 8 at 1282:5-1283:17 (Shadigian, admitting use of serial laminara was "not unsafe").

The government notes in response that the fact that these studies involved a relatively small number of participants, and followed only a limited number of women who returned to the same hospital where the abortion was performed for care in their subsequent pregnancies, might have skewed the results. *See, e.g.*, Tr. Vol. 6 at 919:8-25 (Bowes); Tr. Vol. 7 at 1105:20-1106:23 (Sprang).

Plaintiffs also cite the AMA task force's report on second trimester abortion, which concluded that there was insufficient medical research or evidence to conclude that dilation increases the risk of cervical incompetence, and noted that the government's witness Dr. Sprang was a member of that task force. Tr. Vol. 7 at 1147:8-1148:6 (Sprang). Also, practitioners report that they have not seen in their practices any increased incidence of cervical incompetence for subsequent pregnancies after intact D & E. Tr. Vol. 11 at 1734:2-25 (Chasen).

ii. Infection

The government also claimed, and plaintiffs acknowledged, that the insertion of the laminaria could potentially rupture the amniotic sac, introduce bacteria from the vagina into the uterus, and increase the risk of a woman's chance of infection. Tr. Vol. 7 at 1082:19-1085:17 (Sprang); *see also* Tr. Vol. 4 at 626:3-7 (Broekhuizen). Plaintiffs' experts testified, however, they have never encountered this actual situation except in cases where the amniotic sac had already ruptured, which predisposes the uterus to infection. *See, e.g.*, Tr. Vol. 11 at 1719:23-1720:10 (Chasen).

iii. Injuries from Podalic Version

Not all doctors perform a podalic version before commencing D & Es of any kind, but the doctors who do stated that rotation of the fetus is naturally effected as part of the procedure when the doctor takes hold of a fetal extremity and begins the extraction process, for any D & E. Furthermore, any placental separation that might occur does not pose a problem because the placenta will be removed in the extraction process in any event, and the risk of amniotic fluid embolus is nonexistent, because all amniotic fluid is removed from the uterus before a D & E begins. No doctors who perform podalic version preliminary to an intact D & E reported any of the complications discussed by the government's witness, Dr. Sprang. *See, e.g.*, Tr. Vol. 4 at 516:8-518:6 (Broekhuizen); Tr. Vol. 4 at 668:18-678:4 (Creinin, discussing and discounting all purported risks); Tr. Vol. 5 at 827:19-829:1 (Westhoff). Moreover, plaintiffs note that Dr. Sprang's citation for these complications comes directly from a textbook on full-term delivery, where the fetus is significantly larger than it is in the second trimester, and furthermore, that

the references to the complications were removed in subsequent editions of the textbook. Tr. Vol. 7 at 1087:24-1089:1 (Sprang, speculating that section of the text was removed for space considerations).

iv. Injury from Instrumentation

The government also claims that the use of the trocar or scissors to reduce the size of the fetal head could cause injury to the woman if the instrument slips, especially when the instruments are used blindly, without the doctor's being able to see where the instruments are being inserted. This appears to be based on Dr. Haskell's 1992 description of the intact D & E procedure. The government also argues that if the fetal head is crushed with forceps before removal, the sharp ends of the skull fragments may pose a risk of laceration to the woman. Tr. Vol. 7 at 1089:25-1091:14 (Sprang). *But see* Tr. Vol. 7 at 1127:8-1128:12 (Sprang, arguing no risk of laceration or injury if ultrasound is used).

While the plaintiffs concede that laceration by instruments used to crush the skull or by fragments of fetal bones can pose a risk to women's health, plaintiffs argue that intact D & E reduces the amount of risk from such laceration. Tr. Vol. 1 at 110:25-111:17 (Paul); Tr. Vol. 2 at 271:3-16, 273:3-14 (Sheehan), Tr. Vol. 3 at 445:4-446:23 (Doe); Tr. Vol. 4 at 631:18-634:2 (Broekhuizen).

Of the testifying doctors who perform intact D & E by puncturing the calvarium, none insert the trocar or scissors blindly; rather, they all visualize the insertion point either directly or through ultrasound. Tr. Vol. 4 at 632:2-8, 638:18-640:7 (Broekhuizen); Tr. Vol. 4 at 682:14-19 (Creinin); Tr. Vol. 5 at 801:25-802:5, 818:8-11 (Westhoff). Cf. Tr. Vol. 7 at 1136:7-14 (Sprang, agree-

ing that visualization would reduce risk). Similarly, when fetal bones are crushed, the doctor takes special care to ensure that the bone fragments are covered with the forceps when removing them through the cervix.[31]

Of plaintiffs' experts, only a few testified that they had ever perforated a uterus while performing a D & E, and the ones who had, had done so only when performing a D & E by disarticulation. No expert had perforated a uterus while performing an intact D & E. *See* Tr. Vol. 1 at 73:13-18, 123:12-125:25 (Paul); Tr. Vol. 2 at 195:3-12 (Sheehan); Tr. Vol. 5 at 800:5-12 (Westhoff); Tr. Vol. 11 at 1755:24-1756:6 (Chasen).

f. Maternal and Fetal Health Concerns

Finally, plaintiffs presented evidence that for certain women or certain fetuses, an intact D & E may be the best option for their particular health situation. See, e.g., Tr. Vol. 11 at 1762:8-25 (Chasen, noting that intact D & E is the quickest and therefore the safest procedure for these women); see also Tr. Vol. 6 at 943:4-944:19 (government witness Bowes, testifying that doctors should be allowed to use their judgment in determining whether any particular procedure is in a patient's best interest, including intact D & E).

The government presented evidence that even in those circumstances, an intact D & E is never a physician's only option for terminating the pregnancy, and thus the procedure is never medically necessary. The government's position appears to be that induction is almost always a viable option for terminating a second

[31] Furthermore, to the extent that blindly used instruments or skull fragments pose a risk of laceration, the risk would be identical in an intact D & E and a D & E by disarticulation.

trimester pregnancy, and in those rare circumstances when it is not, hysterotomy or hysterectomy would be. Furthermore, D & E by disarticulation also remains an option for women who would otherwise seek an intact D & E. *See, e.g.*, Tr. Vol. 7 at 1109:19-1114:9 (Sprang); Tr. Vol. 8 at 1220:16-21 (Shadigian); Tr. Vol. 9 at 1390:3-22, 1411:22-1416:2 (Cook).

i. Maternal Health

Uterine Scarring

Women with uterine scars, from previous caesarean operations or other uterine surgery, cannot be treated with prostaglandins such as misoprostyl, because the contractions caused by these medications can cause uterine rupture along the scar. Uterine rupture has serious implications for a woman's future reproductive health, and can endanger a woman's life. Accordingly, ACOG strongly discourages the use of prostaglandins for women with uterine scars, and thus doctors ordinarily recommend that women with uterine scars undergoing a second trimester abortion proceed with a D & E. *See, e.g.*, Tr. Vol. 2 at 190:14-20 (Sheehan); Tr. Vol. 3 at 410:20-413:2 (Doe); Tr. Vol. 4 at 506:2-10, 506:25-507:20 (Broekhuizen); Tr. Vol. 5 at 712:9-714:4 (Creinin); Tr. Vol. 6 at 947:4-13 (Bowes).

The government presented evidence that an induction is still possible for such women, as long as milder prostaglandins or different labor inducing drugs are administered and she is well-monitored, but concedes that a risk of uterine rupture still exists. Tr. Vol. 9 at 1413:9-1436:5 (Cook). *But see* Tr. Vol. 3 at 434:13-435:10 (Doe, noting that other drugs are less likely to induce labor successfully); Tr. Vol. 8 at 1285:17-1286:13

(Shadigian, admitting that other drugs may cause uterine rupture).

Blood Loss

Some pregnant women suffer from bleeding-related disorders that render the blood loss inherent in a two-day induction procedure risky to their health. For instance, women with bleeding disorders, on blood-thinning medications, or suffering from renal disease have a propensity to bleed excessively, which makes any extended procedure causing blood loss dangerous. Analogously, pregnant women diagnosed with pre-eclampsia, a rare and potentially fatal condition caused by the pregnancy itself, often lose blood volume as their blood thickens and begins to clot, so even a slight loss of blood can have drastic effects on their health. Women with cardiac or pulmonary disease, including asthma, also cannot tolerate excessive blood loss, because it causes excessive strain on their systems. *See, e.g.*, Tr. Vol. 1 15:14-17:18 (Paul); Tr. Vol. 3 at 383:17-22, 388:3-390:6 (Doe); Tr. Vol. 8 at 1286:14-1287:11 (Shadigian). Thus, plaintiffs presented evidence that women with these health considerations who are undergoing second trimester abortions are better served by the quicker D & E procedure, and particularly by intact D & E. *See, e.g.*, Tr. Vol. 11 at 1763:1-20 (Chasen).

In response, the government presented evidence that with any surgery, there is the risk of traumatic injury, which could cause extreme blood loss as well, and that on balance, it is safer to treat such a woman in the hospital, where her blood loss can be monitored and transfusions can be given if necessary, than in an outpatient setting where there is not likely to be emergency care immediately available. Tr. Vol. 9 at 1391:10-20, 1420:22-1428:2 (Cook); *see also* Tr. Vol. 8 at 1223:8-

1224:2 (Shadigian, recommending induction or hysterotomy for preeclampsia). *But see* Tr. Vol. 9 at 1477:12-1478:16 (Cook, conceding that intact D & E could be performed in a hospital setting).

Placenta Previa

Certain women develop the condition of placenta previa in pregnancy, where the placenta grows over the cervix and thus blocks the cervical opening. The parties agree that an induction cannot be performed in this circumstance because the fetus cannot pass through the blocked opening. Tr. Vol. 3 at 410:12-19 (Doe); Tr. Vol. 4 at 506:14-24 (Broekhuizen). Plaintiffs presented evidence that in this circumstance, the placenta should be removed or pierced in a D & E. Tr. Vol. 11 at 1768:5-21 (Chasen).

The government, however, takes the position that a D & E is not indicated in this circumstance. The government witnesses would instead recommend that a hysterotomy be performed, even though the hysterotomy is significantly riskier than a D & E and has serious implications for the woman's future reproductive health. Tr. Vol. 9 at 1428:3-1429:10 (Cook, stating that in later gestational ages, hysterotomy or caesarean delivery is the way to deliver a baby with placenta previa).

Uterine Infections

Women sometimes develop uterine or amniotic infections during pregnancy, and if these infections are not treated, they can lead to sepsis, or a generalized blood infection, which can spread throughout the body. If that happens, the uterus must be emptied immediately. Plaintiffs presented evidence that an induction would not be appropriate in that circumstance because the

procedure takes too long and the woman's health could be compromised while waiting for the fetus to deliver. Tr. Vol. 11 at 1766:19-1767:5 (Chasen).

In response, the government presented evidence that if an infection is present, the D & E surgery could potentially spread the infection if the uterus were perforated, and that induction would be acceptable as long as the woman was closely monitored over the two-day period. Tr. Vol. 9 at 1400:12-1401:1, 1429:14-1430:16 (Cook); see also Tr. Vol. 8 at 1224:3-22, 1266:23-1268:10 (Shadigian).

Emergency Situations

The government witnesses testified that if time was of the essence and a pregnancy needed to be terminated immediately, an intact D & E would take too long as well, since the cervix must be prepared over a two day period, and that a hysterotomy or hysterectomy would be the quickest way to proceed. Tr. Vol. 8 at 1227:6-12 (Shadigian); Tr. Vol. 9 at 1436:12-1437:12 (Cook). Plaintiffs agreed that D & Es in general require several hours of cervical preparation, though in certain situations, when misoprostyl and osmotic dilators are used, the cervix can be dilated in as little as 90 minutes. *See, e.g.*, Tr. Vol. 1 at 59:9-11 (Paul).

Psychological Reasons

Finally, many women do not wish to undergo inductions, primarily for psychological and emotional reasons Some women do not wish to go through the physical and psychological pain of labor if the pregnancy is to be terminated, especially if the termination is for medical reasons, and some women also prefer having a quicker outpatient procedure, rather than checking into a hospital as is required for an induction. *See, e.g.*, Tr. Vol. 1 at 91:17-92:1 (Paul), Tr. Vol. 3 at 457:1-458:10 (Doe); Tr. Vol. 4 at 503:22-504:3 (Broekhuizen); Tr. Vol. 5 at 802:11-803:19 (Westhoff), Tr. Vol. 11 at 1773:23-1776:10 (Chasen). *But see* Tr. Vol. 8 at 1277:22-1278:3 (Shadigian, stating that labor pains from induction should not be characterized as "traumatic").

ii. Fetal Anomalies

Fetuses sometimes have anomalies that can create contraindications for induction. Examples of this include hydrocephaly, ascites, or non-immune hydrops, where fluid collects in the fetal head, abdomen, or extremities and grossly distends those portions of the fetal body. In those circumstances, the fetal body may be so distended that it cannot be removed from the uterus unless reduced in size. Tr. Vol. 4 at 499:9-22 (Broekhuzien); Tr. Vol. 9 at 1446:16-1447:7 (Cook). These conditions can be, but are not always, fatal to the fetus. Tr. Vol. 7 at 1114:5-9 (Sprang); Tr. Vol. 9 at 1447:8-1448:5 (Cook).

If a D & E is performed, many doctors will remove all portions of the fetus from the uterus except for the oversized portion, and then take a deliberate action to reduce the size of the distended body part so that it too can be removed. All parties agree that this action could

violate the Act if it caused fetal demise. Plaintiffs argue that this type of intact D & E is the best way to terminate a pregnancy where these conditions are present. Tr. Vol. 11 at 1759:8-1760:22 (Chasen).

The government argues that doctors could instead use a hypodermic needle to aspirate the fluid from the distended body part before the abortion is performed and proceed with either an induction or D & E by disarticulation. Tr. Vol. 7 at 1113:21-1114:9 (Sprang); Tr. Vol. 9 at 1446:16-1447:7 (Cook). Plaintiffs rebut this argument by stating that in some circumstances, fluid would refill the body part before the abortion could be completed, which would render aspiration futile, and furthermore, that there is no reason to subject the woman to an additional injection and the concomitant risks associated with it when an intact D & E procedure achieves the same end more efficiently. Tr. Vol. 11 at 1759:23-1762:7 (Chasen).

The government responds by arguing that if an injection is contraindicated, a hysterotomy or hysterectomy could be performed instead to terminate the pregnancy. The government also argues that the induction could be completed to the point at which the fetal body part lodges in the cervical os, and then "Duhrssen's incisions" of approximately 1-2 cm in length could be made in the cervix to widen the os sufficiently for the fetus to pass. Plaintiffs contend that Duhrssen's incisions are extremely risky to the woman's future fertility, while the government argues that when properly performed they do not represent any serious risk. *Compare* Tr. Vol. 4 at 533:18-534:24 (Broekhuizen, stating that Duhrssen's incisions not appropriate to use in an induction); Tr. Vol. 11 at 1787:3-4 (Chasen) *with* Tr. Vol. 9 at 1509:20-1513:25 (Cook).

6. Fetal Demise

The Act does not proscribe intact D & Es performed after the death of the fetus. Thus, the government contends that if an intact D & E were ever necessary, the doctor could simply effect fetal demise before performing the procedure to escape liability under the Act. *See, e.g.*, Tr. Vol. 7 at 1114:10-13 (Sprang).

Plaintiffs argue that effecting fetal demise before a D & E is unnecessary, and doctors should not be required to subject their patients to an additional medical procedure that poses some risk and no benefit to the patient solely to protect themselves from liability. Tr. Vol. 2 at 291:5-20 (Drey); Tr. Vol. 5 at 727:22-728:4 (Creinin); Tr. Vol. 5 at 819:20-820:5 (Westhoff). *See also* Tr. Vol. 2 at 334:19-335:14 (Drey) (stating that it would be "a very painful decision" for her to begin using digoxin to avoid liability under the Act because "I wouldn't even have any idea how to consent a patient if I am giving digoxin for my benefit as a provider. . . . I wouldn't be saying that this is for her clinical benefit. . . . It is for me. I would feel very much forced to do something to a patient that wasn't for her. That would just really be awful for me.").

a. Injection Techniques

Fetal demise can be effected in a number of ways, but the methods primarily discussed at trial were the injection of either digoxin or potassium chloride ("KCI") through the woman's abdomen and either into the amniotic fluid ("intra-amniotically") or directly into the fetus' heart ("intra-cardiac" or "intra-fetal injection"), both of which are toxic to the fetus.

Digoxin can be administered either intra-amniotically or through an intra-cardiac injection, while KCI can

only be administered intra-fetally. Tr. Vol. 2 at 295:9-25 (Drey). It is relatively simple to inject digoxin intra-amniotically, but intra-amniotic injection is not always effective in causing fetal demise. An intra-cardiac injection of either KCI or digoxin is virtually 100% effective, but requires more skill to perform, and thus is typically performed only by maternal-fetal medicine obgyn specialists. Tr. Vol. 2 at 197:15-198:7, 243:25-245:1 (Sheehan); Tr. Vol. 2 at 312:7-24 (Drey); Tr. Vol. 6 at 964:18-968:17 (Bowes); Tr. Vol. 11 at 1780:20-1782:24 (Chasen).

After fetal demise, the fetal tissue rapidly undergoes a number of physiological changes, so by the time the D & E begins, the tissue is much softer and will disarticulate more easily (known as tissue "friability"). Tr. Vol. 2 at 243:16-24 (Sheehan); Tr. Vol. 2 at 341:12-25 (Drey); Tr. Vol. 8 at 1284:19-1285:3 (Shadigian). This process, known as "maceration," also renders the fetal tissue unusable for autopsy or diagnostic testing. Tr. Vol. 11 at 1758:7-19, 1781:25-1782:5 (Chasen).

Some doctors effect fetal demise routinely as part of their D & E practice, while others have only done so upon direct request by the patient. Some doctors report that some of their patients are strongly opposed to causing fetal demise before the procedure begins, while other doctors indicate that their patients strongly prefer that an injection be given. *Compare* Tr. Vol. 2 at 196:5-20, 242:12-243:2 (Sheehan, stating that all patients accept digoxin injection) *with* Tr. Vol. 2 at 342:9-15 (Drey, stating that some patients find digoxin upsetting); Tr. Vol. 3 at 418:2-15 (Doe, stating that patients generally do not want fetal demise effected upon discussion); Tr. Vol. 4 at 561:15-562:22 (Broekhuizen, say-

ing that opinions on this issue differ sharply among his patients).

b. Risks of Procedure

As with any medical procedure, there are risks associated with these injections, which include bleeding and infection. While these risks are minimal, they can have significant ramifications for women with certain medical conditions, such as HIV or hepatitis. The injection itself is also uncomfortable, and some women experience nausea or vomiting afterwards. Tr. Vol. 2 at 197:2-14 (Sheehan); Tr. Vol. 2 at 314:14-329:20 (Drey); Tr. Vol. 3 at 417:6-419:19 (Doe); Tr. Vol. 5 at 728:5-19 (Creinin); Tr. Vol. 6 at 968:25-969:6 (Bowes).

After fetal demise is effected, some women will also spontaneously miscarry the fetus before surgical extraction begins, which can be distressing, particularly if the woman is not in the hospital at the time. Tr. Vol. 2 at 198:12-13 (Sheehan); Tr. Vol. 2 at 296:7-22 (Drey).

Finally, during the procedure, if the fetus has already died, the increased friability of the tissue can increase the risk of leaving fetal parts in the uterus and subsequent infection. Tr. Vol. 2 at 341:23-25 (Drey); Tr. Vol. 5 at 820:6-822:4 (Westhoff, noting that she encountered this situation shortly after the Act was passed and she was using KCl for the first time, and believes she may have caused a uterine perforation as a result of the softened tissue).

c. Scientific Studies

Dr. Drey has conducted two prospective randomized studies on the safety and efficacy of intra-amniotic injections of digoxin, and has concluded that while digoxin is generally safe to use, it did not improve the

performance of D & E abortions in any significant way. *See generally* Tr. Vol. 2 at 291:5-20 (Drey).

For the safety aspect of the study, Drey followed eight women who received intra-amniotic digoxin injections before their second trimester abortions and monitored their reactions to the drug. The study concluded that digoxin was generally safe for use in women for whom digoxin was not contraindicated. Exh. 34 (article); Tr. Vol. 2 at 305:4-314:14 (Drey).

Drey and her colleagues then studied the efficacy of the drug in facilitating D & E abortions. In that study, the doctors followed 126 women, 62 of whom received digoxin injections before their abortions and 64 of whom did not. The doctors performing the abortions could not tell the differences between the groups, and the study found no benefit to either the doctors or the women from having the injection. Women who received digoxin injections reported significantly higher incidents of vomiting. The report also demonstrated that intra-amniotic injections failed to cause fetal demise in 8% of the women. Exh. 30 (article); Tr. Vol. 2 at 314:14-329:20 (Drey).

The article on the efficacy of digoxin concluded that "[digoxin] did not decrease procedure time, difficulty, or pain compared to placebo," and thus recommended its use only when a patient specifically requests fetal death before the procedure begins. Exh. 30. Accordingly, UCSF discontinued the routine use of digoxin in second trimester abortions. Tr. Vol. 2 at 328:24-329:11 (Drey).

d. Contraindications

Some women have contraindications for these injections. For example, women with heart conditions should not receive digoxin injections because if the digoxin inadvertently enters the woman's bloodstream, it could cause major heart damage. Women who have low amniotic fluid levels or who have had a rupture of the amniotic sac cannot be monitored with ultrasound or receive intra-amniotic injections. Injections are also contraindicated for morbidly obese women, if the hospital is unable to provide needles long enough to inject into the woman's uterus. Tr. Vol. 2 at 308:10-3:10:18 (Drey); Tr. Vol. 6 at 964:10-17, 968:21-24 (Bowes); Tr. Vol. 11 at 1781:10-24 (Chasen).

e. Cutting of Umbilical Cord

The other method of causing fetal demise discussed at trial was the cutting of the fetal umbilical cord at the beginning of the D & E extraction procedure, which cuts off the fetal blood and oxygen supply. The cord is not always accessible to the doctor, though, and once the cord is cut, it can take up to five to ten minutes for fetal demise to occur. Tr. Vol. 7 at 1119:12-20 (Sprang); Tr. Vol. 11 at 1782:6-21 (Chasen).

7. Fetal Pain

Finally, the government presented testimony on the issue of fetal pain, in support of the congressional finding that fetuses do feel pain. There is no consensus of medical opinion on the issue.

a. Physiology

The fetus develops the basic elements and connections of a nervous system by approximately 20 weeks

after conception.[32] Fetuses at this age have been observed to respond to outside sensory stimuli such as sound, light, and smell, and when fetuses undergo stressful stimuli, such as fetal surgery or fetal blood transfusions, the fetus releases stress hormones and blood flow to the brain increases, just as it does for newborn infants and adults. *See generally* Tr. Vol. 10 at 1570:1-1614:11 (Anand).

However, the fact that the fetus responds to stimuli does not necessarily mean that it feels pain. For the fetus to interpret stimuli as pain requires not only that the fetus respond to stimuli, but also that when the stimulus reaches the brain, the brain interprets it as unpleasant or painful.[33] In other words, the fetus must have developed some form of consciousness to be said to "feel pain." Tr. Vol. 10 at 1626:10-1627:16 (Anand).

The only way that an outside observer can determine whether any entity feels pain is if the entity communicates distress to the observer. The parties agree that fetuses are unable to communicate, so it is impossible to determine conclusively if the stress responses seen in fetuses in fact translate into an actual pain response, and thus no studies on fetal pain suffered during abortions have been conducted. Both parties agreed that as a result, much of the debate on this issue is based on speculation and inference. Tr. Vol. 10 at 1629:24-1630:24 (Anand).

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[32] This is at 22 weeks lmp.

[33] For instance, the body produces a pain response during surgery, but anesthetics block the brain from interpreting those responses as pain. Tr. Vol. 5 at 725:22-726:2 (Creinin).

b. Scientific Debate

i. Early Development of Pain

One group of physicians believe that fetuses feel intense pain starting as early as 22 weeks lmp. These physicians argue that at this point, since the entire nervous system has developed and has connected to the brain, the fetus can be considered to have developed consciousness, and is thus fully able to feel pain. These physicians argue further that since the last part of the nervous system to develop is the nervous system's inhibitory mechanisms, which permit the modulation or blocking of pain impulses, fetuses at this age feel intense pain, even more so than infants or adults. Tr. Vol. 10 at 1570:1-1614:11 (Anand); Tr. Vol. 7 at 1120:4-10 (Sprang).

These physicians admit that they have no way of conclusively determining whether this hypothesis is true, but note that fetuses in this age range often demonstrate shifting patterns of brain wave activity in response to stimuli, much like sentient infants and adults do. They also argue that empirically, fetuses at this age are observed to recoil from outside stimuli, such as needles, that are introduced into the womb. Tr. Vol. 7 at 1046:23-25 (Sprang); Tr. Vol. 10 at 1583:14-1586:5, 1618:1627:7 (Anand); Tr. Vol. 11 at 1823:16-1824:20 (Chasen).

Physicians who ascribe to this school of thought argue that the process of intact D & E, where the skull is collapsed, causes the fetus extreme pain. These doctors also believe that a D & E by dismemberment would be excruciatingly painful for the fetus, and that even a needle injection of digoxin or KCI would cause

the fetus pain as well. Tr. Vol. 10 at 1605:16-1608:15, 1666:16-1668:7 (Anand).

ii. Later Development of Pain

Other physicians believe that the fetus does not develop full consciousness until approximately 26 weeks lmp at the earliest, citing a study conducted by the British Royal College of Obstetricians and Gynecologists, which indicated that the nervous system was not fully integrated until that time. These physicians argue that consciousness cannot be said to be based on an on/off model and instead, should be seen as existing in gradations, so that fetuses before 26 weeks have rudimentary consciousness but not the full consciousness which would enable them to process stimuli as pain. Tr. Vol. 5 at 722:8- 727:21 (Creinin).

These physicians also believe that fetuses cannot be compared to infants or even premature infants, since the birth process and the lack of dependency on the mother makes infants physiologically different from fetuses in utero. While certain physiological markers may look similar, it is possible that the fetal brain interprets these markers differently than it would if the fetus was entirely delivered. Furthermore, these physicians note that physiological markers such as a rise in stress hormones may not necessarily be correlated with the sensation of pain even in adults, so it is impossible to determine what, if anything, the fetus feels in response to these physiological events. Tr. Vol. 10 at 1614:13-1668:8 (Anand, explaining opposing position).

C. Findings of Fact

Having reviewed the trial evidence, the court finds as follows.

1. Credibility of Witnesses

The court found all of the plaintiffs' experts not only qualified to testify as experts, but credible witnesses based largely on their vast experience in abortion practice.

However, of the four government witnesses who were qualified as experts in obgyn, all revealed a strong objection either to abortion in general or, at a minimum, to the D & E method of abortion. The court finds that their objections to entirely legal and acceptable abortion procedures color, to some extent, their opinions on the contested intact D & E procedure.

Dr. Sprang testified that he "wouldn't be comfortable actually taking the life of the fetus." In his "practice, if patients want to have an abortion, they are referred to abortion providers." Tr. Vol. 7 at 1060:6-7 (Sprang). Dr. Sprang also testified that he felt so strongly regarding the benefits of induction because it is a more "physiologic" process with less "instrumentation" to D & E post-20 weeks that he would not even discuss D & E as an option with his patients. *Id.* at 1122:20-1123:1. This is in spite of the fact that he admits that post-20 weeks, D & E and induction are comparably safe. *Id.* at 1124:9-10.

Dr. Shadigian is a member of AAPLOG, the American Association of Pro-Life Obstetricians and Gynecologists, and likewise, will not personally perform an abortion on a previable fetus that has not already died unless "the woman is so sick that the only way she is going to survive is to have the pregnancy ended." Tr.

Vol. 8 at 1210:6-21 (Shadigian). Dr. Bowes similarly testified that he would not personally perform an abortion even to save the life of one of his patients unless he believed that there was at least a 50% likelihood that she would die absent the abortion—even if the pregnancy was the result of rape or incest. Tr. Vol. 6 at 977:1-12 (Bowes).

Additionally, Dr. Cook testified that because of his beliefs, he will not perform abortions for "elective" reasons. Tr. Vol. 9 at 1353:25-1354:2 (Cook). Like the other government witnesses, Dr. Cook testified that he strongly prefers inductions because he believes that they are "more physiologic." *Id.* at 1513:5-1514:25. However, the strength of Dr. Cook's preference for induction is not supported by the medical evidence, and there appear to be several circumstances under which Dr. Cook would utilize induction, or an even less safe alternative, hysterotomy, when the medical evidence and literature suggest that the safest procedure is D & E.[34] The court also has some misgivings regarding Dr.

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[34] Dr. Cook asserted that he so strongly preferred induction, that he would prefer to allow a woman who was suffering from an infection of the amniotic membranes called chorioamniocentitis to continue to labor for several hours as opposed to performing a D & E. *Id.* at 1475. Moreover, Dr. Cook also testified that in the case of an induction complication, in which the fetal head became trapped in the woman's cervical opening, he would prefer to utilize Duhrssens' incisions, a series of up to three cervical incisions up to two centimeters long and the full-depth of the cervix, as opposed to performing a D & E. *Id.* at 1512:5-1513:9. He compared the incisions to "cervical lacerations that occur during the normal labor process," and referred to them as "a variation on a normal process," and still "more physiologic" than dilation with laminaria, associated with a D & E. *Id.* at 1512:20. Finally, Dr. Cook stated that he does not consider D & E an option post-20 weeks, and would utilize hysterotomy as opposed to D & E. *Id.* at 1517:2-7.

Cook's credibility based on his extremely equivocal and elusive testimony regarding the medical necessity of D & E under certain circumstances.[35]

Finally, the court notes that Dr. Anand, the government's expert witness on the issue of fetal pain, is not an anesthesiologist, neurologist, obstetrician, or maternal-fetal medicine specialist. Anand is a pediatrician who has conducted research on pain in general, focusing primarily on infants. Tr. Vol. 10 at 1540:6-1568:14 (Anand). Thus, Anand's opinions on fetal pain as they relate to fetal development have been given no more weight than the testimony of other obstetricians and maternal-fetal medicine experts, who reviewed the same material and concluded that fetal consciousness and pain do not exist until at least 26 weeks. *See, e.g.*, Tr. Vol. 3 at 419:20-420:4 (Doe); Tr. Vol. 5 at 722:8-727:21 (Creinin).

2. Findings of Fact Regarding Relevant Abortion Procedures Both D & E and Induction are Safe Procedures

Both D & E and induction are safe procedures, with extremely low rates of morbidity (medical complications) and mortality. Between the two, however, the studies consistently show that D & E is as safe or even significantly safer than induction, and both procedures are greatly safer than either hysterotomy or hysterectomy.

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[35] Dr. Cook contradicted himself several times regarding whether he had ever found D & E to be "medically necessary" in his practice, before agreeing that he found it to be not only medically necessary on occasion, but under certain circumstances, superior to induction. *Id.* at 1459:3-1461:25; 1472:21-24.

Intact D & E is a Variant of the D & E Procedure

Intact D & E is not a separate procedure, but rather, simply a variant of the established D & E technique. While doctors cannot always predict beforehand whether a D & E abortion will proceed by disarticulation or through an intact extraction, the record is clear that some doctors may prefer to perform an intact extraction if at all possible.

Intact D & E v. Induction and Other Abortion Procedures

D & E, including intact D & E presents significant medical benefits over an induction, hysterotomy, or hysterectomy. A D & E, including an intact D & E, takes significantly less time than an induction, and to the extent that up to 10% of inductions require a subsequent D & E to remove unexpelled fetal parts, surgical procedures are not necessarily avoided in an induction. Moreover, other benefits to D & E, including intact D & E, include a reduced exposure to risks and maternal complications associated with induction abortions, including uterine rupture and infection, and a decreased risk of blood loss and infection and complications arising from unexpelled fetal parts.

A D & E, including an intact D & E, also does not require a woman to undergo labor. For this reason, most women strongly prefer a D & E abortion. Moreover, the record is clear that some individual women, for health reasons, cannot undergo an induction abortion. The court finds that it would be unreasonable to expect women for whom inductions are contraindicated to put their health at risk by undergoing induction, hysterotomy, or hysterectomy. While an induction has the benefit that an intact fetus can be obtained for autopsy or psychological grieving purposes, an intact D

& E can have the same result without requiring women to undergo induced labor.

Intact D & E v. D & E by Disarticulation

The existing studies show that intact D & Es are at least as safe as D & Es by disarticulation. Exh. 27 (Chasen report). While the Chasen study indicates neither that intact D & E is in every circumstance safer than D & E by disarticulation, nor that intact D & E is in every circumstance less safe than D & E by disarticulation, and cannot be considered conclusive on the issue, even the government's expert Dr. Bowes agrees that such small-scale studies are an important first step in designing further studies on the issue. Tr. Vol. 6 at 960:23-961:8 (Bowes, discussing Chasen report). Thus, these preliminary results indicate the relative safety of intact D & E, and provide valuable information for doctors in exercising their clinical judgment.

Furthermore, the court finds that it is wholly appropriate for doctors, in their best medical judgment, to rely on their clinical judgment and these relatively small-scale retrospective studies in determining, with their patients, whether they wish to perform intact D & E abortions—just as the government's experts rely on their clinical judgment (or "intuition") in recommending induction abortions over D & E abortions, despite the lack of studies indicating that modern induction abortions are superior to D & Es and despite the fact that D & E remains overwhelmingly the procedure of choice for women undergoing second trimester abortions. *Cf.* Vol. 8 at 1302:15-1303:24 (Shadigian, defending her position that induction is safest method of late second trimester abortion).

Moreover, all of the doctors who actually perform intact D & Es concluded that in their opinion and clinical judgment, intact D & Es remain the safest option for certain individual women under certain individual health circumstances, and are significantly safer for these women than other abortion techniques, and are thus medically necessary. *See also, e.g.*, Cain Depo. at 205:14-210:16 (ACOG policy reflecting same finding). These doctors are all well-respected in their practices, and their expertise in recommending and performing D & E and intact D & Es is unassailable. As noted, the court accepts their testimony over that of the government witnesses, who, while also well-respected and qualified to provide testimony in general on obgyn practice and safety, do not perform intact D & Es and who were not qualified to testify as experts on the practice.

The evidence also demonstrates that intact D & E presents significant safety benefits over D & E by disarticulation under certain circumstances for the following reasons, including: (1) fewer passes are made with the forceps and/or other instruments, resulting in a reduced risk of lacerations to the cervix and/or uterus; (2) since the fetus is removed either intact or largely intact, there is a reduced risk of inadvertently leaving fetal parts in the uterus and thus a reduced risk of infection; (3) because the fetus is removed intact or partially intact, there is a reduced risk of injury to the woman caused by the removal of bony fetal fragments; and (4) there may be a reduced operating time, which likewise decreases the risks associated with blood loss and infection.

Alleged Risks of Intact D & E

There also appears to be little risk from the various elements of an intact D & E procedure. As an initial matter, not all doctors perform all four ACOG elements of an intact D & E, so to the extent that certain doctors do not perform certain elements, the attendant risks are nonexistent for their patients. In addition, no doctors who actually perform intact D & Es have reported any of the claimed risks from podalic version or infection caused by laminaria. Dr. Sprang, who has never performed an intact D & E, provided testimony that may be more appropriate in the context of a full-term birth, but it is of limited relevance to an inquiry into the safety of intact D & E.

The government also has not shown that intact D & E increases a woman's likelihood of cervical incompetence. While the Kalish and Chasen studies are not conclusive, they provide strong preliminary evidence that no correlation between the two exists. The methodological problems with the Henriet study, as well as the fact that it primarily addresses first trimester abortions, renders it of limited relevance to this inquiry.

On the question of uterine laceration, plaintiffs admit there is a risk of injury caused by misplaced instruments or fetal bone fragments from the collapsed fetal skull. However, it appears that this risk is minimal, and it does not appear to be any greater than the risk of laceration from D & Es by disarticulation in general. Furthermore, the physicians who perform this procedure state that this risk is greatly minimized by the use of ultrasound guidance and direct visualization.

Fetal Demise

The evidence shows that there is no medical benefit to causing fetal demise before beginning a D & E procedure, including intact D & Es, except potentially as psychological comfort to some, but not all, women. It does not make the abortion procedure safer, easier, or quicker, and the injection procedure itself is not without risk.

Furthermore, each method of causing fetal demise has serious drawbacks. While most doctors can inject digoxin intra-amniotically, this method is not always effective in causing fetal demise, which would defeat the purpose for its use and place doctors using this method at risk of prosecution. While intra-cardiac injection is almost always effective, not all hospitals and virtually no clinics have access to maternal-fetal medicine specialists to perform the injection. In addition, a number of women will be unable to tolerate the injection process.

While cutting the umbilical cord will guarantee fetal demise, it is not always possible to reach the cord in utero. Also, the doctor performing the abortion would have to wait five to ten minutes before death occurred with the woman under sedation and prepared for surgery, which would almost double the time of the extraction procedure.

Fetal Pain

The issue of whether fetuses feel pain is unsettled in the scientific community. However, it appears to be irrelevant to the question of whether intact D & E should be banned, because it is undisputed that if a fetus feels pain, the amount is no less and in fact might be greater in D & E by disarticulation than with the

intact D & E method. Tr. Vol. 10 at 1605:16-1608:15, 1666:16-1668:7 (Anand).

Intact D & E May Be Significantly Safer For Some Women Under Certain Circumstances

In conclusion, the court finds that intact D & E is in fact the safest medical option for some women in some circumstances and is significantly safer than induction, hysterotomy, or hysterectomy for terminating a second trimester pregnancy, and under certain circumstances, also significantly safer than D & E by disarticulation.

However, plaintiffs have not demonstrated the existence of any particular situation for these women for whom induction is contraindicated in which an intact D & E would be a doctor's only option to preserve the life or health of a woman. The government is correct that for most women, a D & E by disarticulation could be utilized instead of induction when contraindications for induction exist. Furthermore, plaintiffs concede that an intact D & E abortion cannot be guaranteed before the extraction procedure begins. A woman can request that an intact D & E be attempted, but the doctor cannot guarantee that it will occur. *See, e.g.*, Tr. Vol. 2 at 190:5-7 (Sheehan), Tr. Vol. 11 at 1758:2-6 (Chasen).

D. Congressional Findings

In support of the Act, the 108th Congress made numerous findings, which are discussed in detail below. The first fourteen findings, (1) through (14), include Congress' interpretation of the United States Supreme Court's decision in *Stenberg*, and Congress' analysis regarding (1) why it believes that it is entitled to make factual findings contrary to those in *Stenberg*; (2) the

degree of deference that Congress asserts the courts should accord its factual findings subsequently set forth in section (14) at (A) through (O); and (3) its ultimate findings regarding the necessity of a health exception. Sections 14(A) through (O) subsequently detail Congress' more specific or particular factual findings pertinent to the issue of a health exception. *See* Act, § 2(1)-(14); (14)(A)-(O).

1. Congressional Legal "Findings" and Interpretations

As noted, some of the "findings" made by Congress include legal interpretations of *Stenberg* and other Supreme Court jurisprudence. There is no dispute that this court reviews issues of constitutional law *de novo*. Accordingly, Congress' legal conclusions and its characterization of the Supreme Court's holding in *Stenberg*, and any additional legal analysis, is not entitled to deference by this court. Nor are any of Congress' legal conclusions, which may be disguised as factual findings, entitled to deference by this court. However, to the extent that such interpretations provided Congress with a framework for its factual findings, the Court discusses those findings below and notes that many of Congress' legal interpretations are inaccurate and mischaracterize Supreme Court precedent.

a. The Congressional Findings Mischaracterize the *Stenberg* Case in Many Respects

Specifically, regarding the *Stenberg* case, Congress, in its findings, mischaracterizes: (1) the Supreme Court's holding regarding "undue burden"; (2) the quantity and quality of the evidence supporting the district court's factual findings; (3) and the Supreme

Court's treatment of the district court's factual findings. *See id.* at § 2(3), (5)-(8).

i. Supreme Court's Holding Regarding Undue Burden

First, Congress incorrectly combined the two bases for the Supreme Court's holding in *Stenberg*, asserting that the Court concluded that the Nebraska law in *Stenberg* posed an undue burden "because it failed to include an exception for partial-birth abortions deemed necessary to preserve the 'health' of the mother." However, as discussed above, this was not the basis for the Supreme Court's holding regarding the law's undue burden on a woman's right to seek an abortion.

Contrary to Congress' assertions, *Stenberg*'s conclusion regarding the necessity of a health exception was distinct from its undue burden analysis, and concerned the ban's impact not on abortion procedures as a whole, but on a smaller group of women: those patients for whom the banned procedure "may bring with it greater safety." *Stenberg*, 530 U.S. at 937, 934, 120 S. Ct. 2597 ("the State cannot prohibit a person from obtaining ['a rarely used'] treatment simply by pointing out that most people do not need it"); *see also Planned Parenthood v. Brady*, 2003 WL 21383721, at *2 (D.Del. June 9, 2003) ("whether [partial-birth abortion] ban poses an obstacle to one . . . woman or thousands does not change the constitutional analysis" of the ban's failure to contain a health exception).

ii. District Court Record and Findings and Supreme Court Review of Record

Preliminary to Congress' ultimate finding that a health exception is never medically necessary, Congress also criticized the district court's findings in

Stenberg and the Supreme Court's alleged reliance on those findings. *See* Act, § 2(5)-(8). First, Congress second guessed the *Stenberg* district court's findings, based *not* on the evidence compiled independently by Congress, but instead based on the evidence heard by the district court. Congress asserted that there was a "dearth of evidence in the *Stenberg* trial court record supporting the district court's findings"; and that none of the witnesses in the *Stenberg* case "identified a single circumstance during which a partial-birth abortion was necessary to preserve the health of a woman." Act, § 2(6); (14)(D).

While this court will not attempt to second guess the findings made by the district court in *Stenberg*, which was in a much better position to evaluate the evidence and the credibility of the evidence before it *at the time of the trial*, this court nevertheless notes that the pertinent congressional findings grossly mischaracterize the state of the trial evidence in *Stenberg*, as reflected in the trial court's reported decisions.

Following an evidentiary hearing, the district court in *Stenberg* held, based on the evidence before it, that Nebraska's partial-birth abortion law was likely to be found unconstitutional after a trial on the merits, and should be preliminarily enjoined. *See Carhart v. Stenberg* ("*Carhart I*"), 972 F. Supp. 507 (D. Neb. 1997).[36] Subsequently, after a trial on the merits, the

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[36] At that stage, as opposed to a trial on the merits, the district court was required to evaluate:

> (1) the threat of irreparable harm to the movant; (2) the state of the balance of the harm and injury that granting the injunction will inflict on other parties; (3) the probability that the movant will succeed on the merits; and (4) the public interest.

district court held that the law, as applied to plaintiff Dr. Carhart and his patients, was unconstitutional because it posed an undue burden and was unconstitutionally vague. *See Carhart v. Stenberg* ("*Carhart II*"), 11 F. Supp. 2d 1099 (D. Neb. 1998).)[37] In support, it found that "[intact D & E] significantly obviates health risks in certain circumstances," a finding that the Supreme Court, in contrast to Congress, subsequently characterized as supported by "a highly plausible *record-based* explanation of why that might be so. . . ." *Stenberg*, 530 U.S. at 936-37, 120 S. Ct. 2597.

The record that the *Stenberg* district court had before it included the Congressional Record that existed to date, an AMA report regarding late-term abortions, CDC data and reports, a January 1997 ACOG policy statement regarding intact D & Es, and the testimony of six expert witnesses, including plaintiffs' witnesses Dr. Carhart, Dr. Jane Hodgson, the founding fellow of ACOG and an obgyn who had supervised and/or performed at least 30,000 abortions at that time, Dr. Phillip Stubblefield, chief obgyn at the Boston Medical Center who regularly performed abortions, Dr. Stanley Henshaw, a director of research at the Alan Guttmacher Institute, who held a Ph.D. in sociology and specialized in non-profit research and writing regarding abortion data; and defense witnesses Dr. Riegel, an obgyn and infertility expert, and Dr. Frank Boehm, the director of obstetrics at Vanderbilt Medical Center. *Carhart II*, 11

Id. at 523 (citing *Dataphase Systems, Inc. v. CL Systems, Inc.*, 640 F.2d 109, 113 (8th Cir. 1981)).

[37] The *Stenberg* district court limited its review to the constitutionality of the Nebraska law as it applied to Dr. Carhart and his patients only, declining to decide generally the facial validity of the state law. *See id.* at 1119-1120.

F. Supp. 2d at 1116.[38] Accordingly, the evidence before the district court in *Stenberg* cannot credibly be characterized as a "dearth of evidence."

Additionally, Congress asserted that the *Stenberg* district court failed to "identif[y] a single circumstance *during which a partial-birth abortion was necessary to preserve the health of a woman.*" Act, § 2(14)(D). This assertion is somewhat misleading because at the time of the trial before the district court in 1998, the Supreme Court had not enunciated the requirement of a health exception with respect to partial-birth abortion bans. Therefore, to the extent that Congress intended to imply that the evidence before the district court was deficient on this basis, it ignored both the chronology of the *Stenberg* case and prior Supreme Court precedent on the issue.

Nevertheless, an examination of the district court record and findings reflects that Congress' assertion is also factually erroneous. First, there was record evidence in support of the district court's findings regarding the safety ~~of intact~~ D & E generally. The district court cited to substantial record evidence in support of its conclusion that intact D & E, as applied to Dr. Carhart and his patients, was "the safest procedure in certain circumstances." *Carhart II*, 11 F. Supp. 2d at 1122. Specifically, the district court relied on Dr. Hodgson's "credible" testimony that the "[intact D & E] procedure [was] 'an advance in technology' because

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[38] The district court, however, found that Dr. Riegel's testimony regarding abortion procedures lacked credibility due to the fact that he lacked experience and was poorly informed regarding the intact D & E procedure, having not performed any abortions due to moral objections, and having never even observed, let alone performed, a D & E or intact D & E. *Id.* at 1116.

by removing the fetus intact there is 'less instrument manipulation' and greater safety"; the corroborating testimony of Drs. Carhart and Stubblefield, whose testimony the district court found "particularly persuasive" given that "[Stubblefield] possessed the most extensive training, experience, and knowledge about the use and teaching of abortion procedures"; the testimony received by district courts in two other cases involving state partial-birth abortion bans, which included the testimony of at least two experts in the case at hand, Drs. Westhoff and Cook; and Dr. Haskell's testimony before Congress. *See id.* at 1107-08, 1116, 1123 (incorporating prior decision).

Moreover, and most importantly, the district court specifically found based on the trial evidence, and contrary to Congress' assertion otherwise, that as a result of Nebraska's partial-birth abortion ban, approximately "10 to 20 women a year . . . could not receive the best care from Dr. Carhart . . . [and] would be forced against their will to endure appreciably greater risks to their health and lives than are necessary." *Id.* at 1127. In support, the district court found that:

> "[a]mong other things, [these women] would suffer a larger than necessary risk of: (1) longer operating time; (2) greater blood loss and infection; (3) complications from bony fragments; (4) instrument-inflicted damage to the uterus and cervix; (5) exposure to the most common causes of maternal mortality (DIC and amniotic fluid embolus); [and] (6) 'horrible complications' arising from retained fetal parts."

Id.

Congress also implies that the Supreme Court blindly deferred to the allegedly erroneous factual findings by the district court, and that the law regarding judicial standards of review required such blind deference. *See* Act, § 2(6)-(8). Specifically, Congress found that:

> Despite the dearth of evidence in the *Stenberg* trial court record supporting the district court's findings, the United States Court of Appeals for the Eighth Circuit and the Supreme Court *refused to set aside* the district court's factual findings because, under the applicable standard of appellate review, they were not 'clearly erroneous.'
>
> . . . .
>
> Thus, in *Stenberg*, the United States Supreme Court *was required to accept the very questionable findings* issued by the district court judge.

Id. at § 2(6),(7).

Neither is the case. Putting aside Congress' disparaging characterization of the district court's factual and evidentiary findings, this court notes that, as a matter of law, the Supreme Court will not blindly defer to factual findings that are as questionable as Congress portrays the *Stenberg* district court's factual findings to have been. *See, e.g., Easley v. Cromartie*, 532 U.S. 234, 121 S. Ct. 1452, 149 L. Ed. 2d 430 (2001) (reversing district court's determination that North Carolina's Legislature used race as the "predominant factor" in drawing Congressional district boundaries). In reviewing a trial court's findings for "clear error," the Supreme Court "will not reverse a lower court's finding[s] of fact simply because [it] 'would have decided the case differently.'" *Id.* at 242, 121 S. Ct. 1452 (quoting *Anderson*

v. Bessemer City, 470 U.S. 564, 573, 105 S. Ct. 1504, 84 L. Ed. 2d 518 (1985)). However, where a review of the trial court's findings "leaves [the Court] 'with the definite and firm conviction' that the District Court's key findings are mistaken," it will reverse those findings. *Id.* at 242-43, 121 S. Ct. 1452 (quoting *United States v. United States Gypsum Co.*, 333 U.S. 364, 395, 68 S. Ct. 525, 92 L. Ed. 746 (1948)) (noting that although the Court had "given weight to the fact that the District Court was familiar with [the] litigation, heard the testimony of each witness, and considered all the evidence with care," the Court "[n]onetheless . . . cannot accept the District Court's findings as adequate").

Nowhere in the Supreme Court's decision in *Stenberg* does the Court imply that there was an inadequacy or insufficiency of relevant evidence before the district court; nor does the Court imply that it considered the district court's findings to be "very questionable." As noted, to the contrary, the Supreme Court approved of the district court's ultimate finding that intact D & E "significantly obviates health risks in certain circumstances" as a "highly plausible record-based explanation. . . ." *Stenberg*, 530 U.S. at 936-37, 120 S. Ct. 2597. Moreover, the Supreme Court clearly conducted its own review of the record evidence before the district court, and summarized the evidence in its decision. *See id.* at 923-30, 120 S. Ct. 2597 (noting that "[t]he evidence before the trial court, as supported or supplemented in the literature, indicates the following").[39]

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[39] Congress also mischaracterized the effect of *Stenberg* on legislative determinations, asserting that *Stenberg* "render[ed] null and void the reasoned factual findings and policy determinations of the United States Congress. . . ." Act, § 2(7). However, that conclusion again ignores the chronology of events. At the time that

2. Congressional Findings Regarding Necessity of a Health Exception

Congress also proffers its interpretation of the law regarding judicial review in an attempt to justify its ultimate "finding," contrary to the Supreme Court's decision in *Stenberg*, that the Act is "not required to contain a 'health' exception . . . because a partial-birth abortion is *never* necessary to preserve the health of a woman." Act, § 2(13) (emphasis added).

Congress interprets the *Stenberg* Court's requirement that partial-birth abortion bans contain a health exception "where it is necessary, in appropriate medical judgment for the preservation of the life of the mother," as a finding of fact unique to the facts in *Stenberg*, and, therefore, susceptible to contrary congressional fact-finding. *See id.* at § 2(4)-(13). Accordingly, Congress "finds" that it is "entitled to reach its own factual findings [on the issue]—findings that the Supreme Court [is required to] accord[ ] great deference—and to enact legislation based upon these findings so long as [Congress] seeks to pursue a legitimate interest that is within the scope of the Constitution, and draws reasonable inferences based on substantial evidence." *Id.* at § 2(8). In support, Congress cites to and discusses several Supreme Court cases for its assertion that the courts "owe Congress' findings an additional measure of deference out of respect for its authority to exercise the legislative power." *Id.* at § 2(12). Congress' "findings" then conclude for the courts that its ultimate finding reflects the "very informed judgment of . . . Con-

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Stenberg was decided, prior Congresses may have voted to ban "partial-birth abortions," but none of those bans had been signed into law.

gress" and is supported by "substantial record evidence." *Id.* at § 2(13).

However, Congress' assertion that the courts are required to defer to its "factual" findings raises questions regarding: (1) the nature of the Supreme Court's holding that a health exception was required in the *Stenberg* case; and (2) Congress' ability to make factual findings contrary to the Court's holding.

a. *Stenberg* Court's Ruling Regarding Necessity of Health Exception

Accordingly, this court examines the *Stenberg* Court's determination that the Nebraska statute was unconstitutional because it "lack[ed] any exception 'for the preservation of the . . . health of the mother.'" "530 U.S. at 930, 120 S. Ct. 2597 (citing *Casey*, 505 U.S. at 879, 112 S. Ct. 2791).

The *Stenberg* Court reiterated its prior holdings in *Roe* and *Casey* that "subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe abortion *except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.*" *Id.* at 921, 120 S. Ct. 2597 (quoting *Casey*, 505 U.S. at 879, 112 S. Ct. 2791). Noting that the Nebraska statute, like the Act at issue in this case, applied both pre- and postviability, and that "the State's interest in regulating abortion previability is considerably weaker than postviability," the *Stenberg* Court concluded, that since "a health exception [is required] to validate even a postviability abortion regulation, it at a minimum requires the same in respect to previability regulation." *Id.* at 930, 120 S. Ct. 2597.

The Court was clear that a health exception is required regardless of whether it is the pregnancy itself, an unrelated health condition, or a "state regulation forc[ing] women to use riskier methods of abortion." 530 U.S. at 931, 120 S. Ct. 2597. The court noted:

> Our cases have repeatedly invalidated statutes that in the process of regulating the *methods* of abortion, imposed significant health risks. They make clear that a risk to . . . women's health is the same whether it happens to arise from regulating a particular method of abortion, or from barring abortion entirely.

Id.

The state of Nebraska, however, asserted that the law did not require a health exception "unless there is a need for such exception," and that there was no need for it in the *Stenberg* case because safe alternatives were available to women and the ban created no risk to the health of women, arguments strikingly similar to the congressional findings in this case.

The Court rejected Nebraska's argument, concluding that, given the "medically related evidentiary circumstances," the Nebraska statute required a health exception. *Id.* at 937, 120 S. Ct. 2597. The "medically related evidentiary circumstances" supporting the Court's determination included: (1) the district court's findings that were supported by the record; (2) "a division of opinion among some medical experts over whether [intact D & E] is generally safer"; and (3) "an absence of controlled medical studies that would help answer these medical questions." *Id.* at 936-37, 120 S. Ct. 2597. Accordingly, the district court findings and record was just one of the three bases upon which the Supreme

Court based its conclusion that a health exception was required.

i. District Court Findings and Record

The Supreme Court found that the district court record "show[ed] that significant medical authority supports the proposition that in some circumstances, [intact D & E] would be the safest procedure." *Id.* at 932, 120 S. Ct. 2597. Moreover, the state of Nebraska failed to rebut the substantial record evidence to this effect. *See id.* (noting that "[t]he State fails to demonstrate that banning [intact D & E] without a health exception may not create significant health risks for women").

The Court then noted the record findings and evidence supporting a health exception, and rejected arguments made by Nebraska in support of its position that no exception was necessary. *See id.* at 934, 120 S. Ct. 2597 ("We find these eight arguments insufficient to demonstrate that Nebraska's law needs no health exception."). The specific eight arguments made by the State that the *Stenberg* Court rejected almost entirely were:

(1) that the intact D & E procedure is "little-used;"

(2) that the intact D & E procedure is used by only a "handful of doctors";

(3) that D & E [by disarticulation] and labor induction are at all times 'safe and alternative procedures';

(4) that the ban does not increase a woman's risk of several rare abortion complications;

(5) Amici Association of American Physicians and Surgeon's ("AAPS") argument that the intact D & E procedure creates its own special risks;

(6) that there are no medical studies establishing the safety of the intact D & E procedure or comparing it to other abortion procedures;

(7) an AMA policy statement that intact D & E is not "the only appropriate procedure to induce abortion"; and

(8) ACOG's qualification of its statement that intact D & E "may be the best or most appropriate procedure" with the fact that ACOG "could identify no circumstances under which [the intact D & E] procedure . . . would be the only option to save the life or preserve the health of the woman."

Id. at 933-937, 120 S. Ct. 2597.

The Court found that several of the above arguments advanced by the State were "beside the point." *Id.* at 934, 120 S. Ct. 2597. First, it held that "[t]he [intact D & E] procedure's relative rarity is not highly relevant." *Id.* The court noted that the health exception was concerned instead

> with whether protecting women's health requires an exception for those infrequent occasions. A rarely used treatment might be necessary to treat a rarely occurring disease that could strike anyone—the State cannot prohibit a person from obtaining treatment simply by pointing out that most people do not need it.

Id. The Court further found that the number of physicians who performed the procedure was not relevant as there was no way of discerning the reason behind those numbers. *Id.*

As for alternative methods, the Supreme Court noted the trial court's agreement that there were "safe alternatives," but rejected Nebraska's argument based on the related district court finding that under certain circumstances, "the [intact D & E] method was significantly *safer*." *Id.* Moreover, regarding complications associated with intact D & E, the Supreme Court implied that there was a split of opinion, and that the trial court had relied on testimony contrary to that relied on by the State, which suggested that intact D & E may eliminate the risk of certain complications. *Id.* at 935, 120 S. Ct. 2597.

The Court also rejected Amici AAPS's arguments regarding special risks associated with intact D & E. The Court noted that another Amici, ACOG, pointed out that the risks highlighted by AAPS are risks generally associated with all abortion procedures, including the alternatives advanced by the State, and were not specifically associated with intact D & E. *Id.* at 935, 120 S. Ct. 2597. Additionally, the court rejected the State's characterization of ACOG's position, especially in light of ACOG's contrary position in its amicus brief. *Id.* at 935-36, 120 S. Ct. 2597 (noting that ACOG asserted that "[intact D & E] presents a variety of potential safety advantages over other abortion procedures used during the same gestational period").

Of the eight arguments, the only ones that the Supreme Court did not reject were Nebraska's assertions regarding the absence of medical studies and the AMA policy statement. However, it did note that Nebraska

had cited only to the most favorable language in the AMA statement, and had omitted a portion of the statement. *Id.* As for the absence of studies, the Court noted that Nebraska was correct that "[t]here are no general medical studies documenting [the] comparative safety of the intact D & E procedure with other abortion procedures." *Id.* at 935, 120 S. Ct. 2597.

ii. Significance of Division of Medical Opinion and Absence of Medical Studies

Expounding on its holding in *Casey*, that "the governing standard requires an exception 'where it is *necessary, in appropriate medical judgment* for the preservation of the life or health of the mother,'" the *Stenberg* Court explained that "necessity" contained in the above phrase "cannot refer to an absolute necessity or to absolute proof"; nor to "unanimity of medical opinion." *Id.* at 937, 120 S. Ct. 2597. It found that the necessity or propriety of a certain procedure depended on the particular circumstances of a particular case, and its relative health risks and/or benefits. *Id.*

The court further noted that "[d]octors often differ in their estimation of comparative health risks and appropriate treatment." *Id.* It, therefore, held that *Casey* requires "the judicial need to tolerate differences of medical opinion." *Id.* The Court noted that the division of medical opinion regarding the safety and propriety of the intact D & E procedure "involve[d] highly qualified knowledgeable experts on both sides of the issue"—division "of a sort that [the AMA] and [ACOG]'s statements together indicate are present here." *Id.*

Accordingly, the Court held that the existence of a divisior of medical opinion supported the need for an exception, as opposed to the contrary. *Id.*

> Where a significant body of medical opinion believes a procedure may bring with it greater safety for some patients and explains the medical reasons supporting that view, we cannot say that the presence of a different view by itself proves the contrary.

Id. The Supreme Court reasoned that such a division of medical opinion meant that there was a "significant likelihood that those [physicians] who believe that [intact D & E] is a safer abortion method in certain circumstances may turn out to be right." *Id.* Accordingly, this likelihood justifies a health exception, because to hold otherwise would "place women at an unnecessary risk of tragic health consequences." *Id.*

In conclusion, the *Stenberg* Court held that:

> [w]here substantial medical authority supports the proposition that banning a particular abortion procedure could endanger women's health, *Casey* requires the statute to include a health exception when the procedure is 'necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.'

Id. at 938, 120 S. Ct. 2597.

b. Relationship of *Stenberg* Health Exception and Related Congressional Findings

The dispute as to congressional factfinding regarding the necessity of a health exception is two-fold: (1) whether the issue is one of fact susceptible to contrary fact-finding by Congress; and (2) assuming that the

issue is one of fact, the degree of deference that this court is required to afford congressional findings on the issue.

At this court's request, the parties briefed those issues pertinent to the deference that this court was required to afford the congressional findings. The parties disagreed as to the characterization of *Stenberg*'s health exception and the appropriate standard of deference, as did law professors in an amicus brief submitted to this court.

i. Plaintiff's Position Regarding Deference to Congressional Findings

Plaintiffs contend that the congressional findings are not really "findings," but an attempt to evade the constitutional standards set forth by the Supreme Court in *Stenberg*. Accordingly, plaintiffs contend that the "findings" should be reviewed *de novo*. *See, e.g.*, *Dickerson v. United States*, 530 U.S. 428, 432, 437, 120 S. Ct. 2326, 147 L. Ed. 2d 405 (2000) (*Miranda* warnings were a "constitutional decision of [the Supreme] Court" and may not be "legislatively supersede[d]" by an Act of Congress); *see also United States v. Morrison*, 529 U.S. 598, 615-617, 120 S. Ct. 1740, 146 L. Ed. 2d 658 (2000) (striking down Violence Against Women Act ("VAWA"), concluding that Congress lacked constitutional power under Commerce Clause and that "the existence of congressional findings is not sufficient, by itself, to sustain the constitutionality of Commerce Clause legislation"); *City of Boerne v. Flores*, 521 U.S. 507, 532, 117 S. Ct. 2157, 138 L. Ed. 2d 624 (1997) (striking down Religious Freedom Restoration Act ("RFRA"), enacted by Congress under Section 5 of the 14th Amendment, "regardless of the state of the legislative record," where Act was in direct response to

a prior Supreme Court decision and sought to legislatively supersede the legal standards set by the Court in that prior case).

ii. Government's Position Regarding Deference to Congressional Findings

The government, on the other hand, argues that this case is distinguishable from the cases cited by the plaintiffs because *Stenberg*'s determination regarding the necessity of a health exception does not rise to the level of a "constitutional rule," like the *Miranda* requirements that Congress sought to overrule in *Dickerson*, or the Supreme Court's constitutional interpretation of the RFRA, which Congress sought to overrule in *City of Boerne*. Instead, the government contends that whether a health exception is required is a "factual" issue, "decided on review of the particular record . . . in the [*Stenberg*] district court."

The government contends that the *Stenberg* Court's conclusion regarding the necessity of a health exception was "inextricably tied to the record evidence compiled in that specific case" and "did [n]ot suggest that Congress could not make an independent assessment of the medical evidence." Accordingly, the government asserts that Congress did not attempt to overrule a constitutional standard, but instead that its findings fell within the constitutional parameters articulated by the Supreme Court in *Stenberg* and *Casey*.

Because it asserts that Congress was entitled to make the contrary factual findings, the government urges this court to apply the standard of review set forth by the Supreme Court in *Turner Broadcasting Sys., Inc. v. FCC ("Turner II")*. 520 U.S. 180, 117 S. Ct. 1174, 137 L. Ed. 2d 369 (1997). In *Turner II*, the

Supreme Court decided the second of a pair of cases involving the appropriate standard of judicial deference due congressional findings of fact in First Amendment free expression cases.

The Supreme Court held in *Turner II* that the "must-carry" provisions of the Cable Television Consumer Protection and Competition Act of 1992, requiring cable television providers to dedicate a portion of their channels to local broadcast television stations, as challenged by cable operators and programmers, did not run afoul of the First Amendment. *Id.* at 224-25, 117 S. Ct. 1174. In so holding, the Court gave substantial deference to congressional findings in support of the regulation. Those findings included Congress' ultimate conclusion that the confluence of undue market influence possessed by cable operators, cable operators' economic interests not to carry broadcast signals, and local broadcasters' reliance on cable operators for access to viewers, together, significantly threatened the future viability of local broadcast television.

In according substantial deference to the legislative findings, the *Turner II* Court noted that its:

> sole obligation is to assure that in formulating its judgment, Congress has drawn reasonable inferences based on substantial evidence. As noted in [*Turner I*], substantiality is to be measured in this context by a standard more deferential than we accord to the judgments of an administrative agency.

Id. at 195, 117 S. Ct. 1174.

Accordingly, the government argues that this court should consider the trial evidence "only to supplement the Congressional record [such] that the Court may

determine whether Congress' judgment was reasonable and based on substantial evidence." *See id.* at 196, 117 S. Ct. 1174 (examining "first the evidence before Congress and then the further evidence presented to the district court on remand to supplement the congressional determination").

iii. Amici's Position Regarding Deference to Congressional Findings

A third and distinct approach regarding the deference to be accorded the congressional findings was advanced by Amici, a group of law professors who teach and write in the area of constitutional law. Amici argue that the necessity of a health exception under *Stenberg* is not a pure fact as the government would characterize it, but instead a constitutional or "legislative" fact. *See, e.g., A Woman's Choice—East Side Women's Clinic v. Newman*, 305 F.3d 684, 688 (7th Cir. 2002) (discussing difference between legislative and adjudicative facts, and noting that Supreme Court had suggested "constitutionality must be assessed at the level of legislative fact, rather than adjudicative fact. . . . [because] only treating the matter as one of legislative fact produces the nationally uniform approach that *Stenberg* demands"); *see also Casey*, 505 U.S. at 888-893, 112 S. Ct. 2791 (ruling that spousal notification requirement placed a substantial obstacle in the path of women seeking to terminate their pregnancies as a matter of law).

While the government would like to characterize *Stenberg*'s health exception as an "adjudicative fact," tried by courts and concerning only the immediate parties to the dispute," Amici note, in contrast, that legislative facts "transcend particular cases and must be decided by courts as a matter of law." March 1, 2004

Amicus brief at 4. According to Amici, the issue here must be treated as one of legislative fact, because otherwise,

> the [government's] proposed standard would create the prospect that different legislatures could find different facts predicated on essentially the same record. . . . Such a result would leave different jurisdictions with disparate constitutional practices notwithstanding the fact that the empirical issue is identical in each of them.

Id. Accordingly, "the necessity of a medical exception must be found at the level of constitutional fact—not amenable to alteration by the fact-finding of individual legislatures." *Id.* at 5.

Amici do not agree with plaintiffs that this court should review the findings *de novo* simply because they constitute legislative or constitutional facts. Nor do Amici agree with the standard advocated by the government.

Amici contend that although the *Turner* standard of deference may apply to legislative facts under some circumstances, that is not true of a case in which a fundamental right, as opposed to economic regulation, is implicated.[40] In cases such as this, involving fundamental rights or liberties, Amici argue that the standard of deference to be applied is a "hard-look"

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[40] Amici also appropriately note that the government's suggestion that the Act at issue here is "economic" simply because it was passed pursuant to Congress' Commerce Clause power mischaracterizes the Act. According to such analysis, all legislation enacted pursuant to Congress' power under the Commerce Clause could be deemed "economic" regardless of its impact on fundamental rights.

standard.[41] Amici acknowledge that the Supreme Court "has not specifically articulated the standard it employs," but contend that "case law makes it clear that the Court stringently reviews proffered findings of fact when basic liberties are infringed, and the Court does not hesitate to go well beyond the legislative record in finding facts regarding the relevant inquiry." March 1, 2004 amicus brief, at 2. According to Amici, this approach requires "that courts conduct a stringent and broadly-based review of the methods and principles underlying factual claims that affect the existence of protection of basic liberties." *Id.*

iv. Analysis Re: Level of Deference

This court is inclined to agree with Amici regarding both the characterization of the Supreme Court's requirement of a health exception in *Stenberg* as one of "constitutional fact," and the applicable standard of deference.

This court's discussion of *Stenberg* above dispels Congress' and the government's characterization of the issue as one of pure fact, limited to the record in that particular case. Instead, as noted, the record was only one of several "medically related evidentiary circumstances" that the Supreme Court considered in concluding that a health exception was required. The other two significant considerations included the state of medical studies and the division of expert medical

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[41] This "hard-look" standard of review is applied only to congressional findings regarding the issue of the necessity of a health exception under *Stenberg*. As for the inquiry regarding undue burden, Amici note that this court is required to make an independent legal judgment regarding whether the Act unduly burdens a woman's right to terminate a pregnancy.

opinion on the issue—general evidentiary considerations that were not limited exclusively to the record in the *Stenberg* case. See 530 U.S. at 879, 120 S. Ct. 2530.

Accordingly, this case appears to be factually closer to those cases relied on by plaintiffs, including *City of Boerne*, *Dickerson*, and *Morrison*, in which the Supreme Court held that, as a matter of law, congressional factfinding was not entitled to deference where Congress intended to legislatively supersede constitutional standards. However, this case is, at the same time, not identical to those cases. As the government has pointed out, those cases involved constitutional "rules." Here, *Stenberg*'s health exception requirement does not appear to arise to the level of a constitutional "rule" like *Miranda* requirements. Instead, because it is based on "medically related evidentiary circumstances," the necessity of the exception is, for the reasons explained by Amici, more appropriately considered an issue of "legislative" or "constitutional" fact.

Assuming that the Supreme Court's holding in *Stenberg* regarding the necessity of a health exception is amenable to subsequent legislative factfinding, this court would be inclined to agree with the "hard look" standard of deference advanced by Amici. That is, that while this court does not review congressional findings regarding these types of facts *de novo*, as plaintiffs have advocated, the court also does not believe the standard is one of substantial deference, advocated by the government. *See also Newman*, 305 F.3d at 688 (noting that with respect to abortion regulations, "constitutionality must be assessed at the level of legislative fact, rather than adjudicative fact determined by more than 650 district judges")." Only treating the matter as

one of legislative fact produces the nationally uniform approach that *Stenberg* demands." *Id.*

This court agrees that the issue of deference in this case is not clearly established by Supreme Court precedent. Because this case involves a woman's fundamental right to choose an abortion, the court is not persuaded that it should afford congressional findings that undermine that right the same substantial deference utilized by the Supreme Court in cases involving economic regulation, like *Turner II*. In *Turner II*, regarding the applicability of the standard of substantial deference, the Supreme Court explicitly noted that:

> [The] principle has special significance in cases, like this one, involving congressional judgments concerning *regulatory schemes of inherent complexity and assessments about the likely interaction of industries undergoing rapid economic and technological change.* Though different in degree, the deference to Congress is in one respect akin to deference owed to administrative agencies because of their expertise.

520 U.S. at 196, 117 S. Ct. 1174 (citing *FCC v. National Citizens Comm. for Broadcasting*, 436 U.S. 775, 814, 98 S. Ct. 2096, 56 L. Ed. 2d 697 (1978)) (emphasis added).

Nevertheless, while recognizing the importance of the issue, this court need not articulate the precise degree of deference to be accorded the congressional findings in this case. That is because, even if this court were to assume that the findings are entitled to the most stringent standard of deference advocated by the government and Congress: that of substantial deference, the court concludes for the reasons set forth

below, that Congress has not drawn reasonable inferences based on substantial evidence, and its findings are therefore not entitled to substantial deference.

3. Congress' Determination that the Partial-Birth Abortion Procedure is Never Medically Necessary is not Reasonable and is not Based on Substantial Evidence

In *City of Boerne*, the Supreme Court recognized that "[o]ur national experience teaches that the Constitution is preserved best when each part of the Government respects both the Constitution and the proper actions and determinations of the other branches." 521 U.S. at 535-36, 117 S. Ct. 2157. In recognition of this principle and the pertinent congressional findings, this court believes it necessary to set forth in detail the history of the congressional proceedings and Congressional Record underlying Congress' ultimate finding, and to discuss the specific findings made by Congress, in support of this court's conclusion that Congress' finding regarding the necessity of a health exception is not entitled to deference.

a. Overview of Congressional Record

In evaluating the congressional findings in this case, it is helpful first to briefly summarize the record before Congress. The evidence presented before Congress was qualitatively different than the evidence presented before this court. While some witnesses testified both before Congress and the court, the court was presented with much more extensive medical and scientific evidence on both sides of the issue concerning the safety and necessity of intact D & Es. Congress, on the other hand, heard significantly more policy-based arguments.

From 1995 to 2003, the 104th through the 108th Congresses held a total of six hearings relating to "partial-birth abortion." In addition, various individuals and organizations submitted numerous policy statements and letters for inclusion in the Congressional Record.[42]

i. 104th Congress (1995)

In 1995, Congress held three hearings on intact D & E.

House Judiciary Committee Hearings

The first hearing of the 104th Congress took place before the House Judiciary Committee on June 15, 1995. Partial-Birth Abortion Hearing before the Subcomm. on the Constitution of the House Comm. on the Judiciary, 104th Cong 1st Sess (1995) ("Record Exh. G"). In those proceedings, various representatives debated the issue of intact D & E in the context of Dr. Haskell's description of the procedure before the National Abortion Federation in 1992.

Two physicians, Dr. Pamela Smith and Dr. Robert White, and one nurse, Mary Ellen Morton, testified in favor of a ban. Dr. Smith, a gynecologist who does not perform abortions, gave a general overview of the procedure, and stated that there was no medical need for the procedure, while Dr. White, a neurosurgeon with no obstetrics training, testified that he believed that the fetus would feel intense pain during an intact D & E procedure. Record Exh. G at 38-44, 90 (Smith testimony), 67-71 (White testimony). Morton, a neona-

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[42] As both parties have agreed, the court takes judicial notice of the fact that materials and testimony are included in the Congressional Record but not necessarily for the truth of the matters asserted therein. *See* Fed. R. Evid. 201.

tal nurse, presented photographs of premature infants and testified in a written statement that she believed that premature infants were identical to fetuses in the second trimester of pregnancy and that they would feel pain during an intact D & E procedure. *Id.* at 76-86.

One physician testified against the ban, Dr. J. Courtland Robinson, an obgyn with training in public health. Dr. Robinson testified that intact D & E is a rare procedure, that the ban seemed vague, and that Congress should not substitute its judgment for those of women and their physicians. Dr. Robinson did not provide information about how an intact D & E is performed, and stated that he was unfamiliar with this technique until a few weeks before testifying. Record Exh. G at 63-67, 88.

One woman, Tammy Watts, who had undergone an intact D & E, also provided testimony. Watts had discovered 7 months into her pregnancy that her fetus suffered from trisomy 13, a fatal chromosomal anomaly, and decided to terminate the pregnancy. Because she had an intact D & E, Watts was able to see and hold the fetus, and the fetus was autopsied for future diagnostic purposes. Record Exh. G at 71-76.

The four testifying witnesses were then questioned by various members of Congress. The witnesses did not provide extensive medical explanations of the procedure, as the representatives focused mainly on policy issues in the debate. Record Exh. G at 86-97.

Various statements were also read into the Record, including newspaper articles on intact D & E, statements from pro-life groups, letters from pro-life doctors, including Dr. Bowes, letters from the National Abortion Federation (a pro-choice organization), a copy

of Dr. Haskell's article and a written response from Dr. Haskell generally objecting to mischaracterizations of his article, and statements from attorneys on the constitutionality of a ban. *See, e.g.*, Exh. G at 4-28, 97-142.

Senate Judiciary Hearings

The second hearing on intact D & E took place before the Senate Judiciary Committee on November 19, 1995. Partial Birth Abortion Ban Act of 1995: Hearing on H.R. 1833 before the Senate Comm. on the Judiciary, 104th Cong. 1st Sess. (1995) ("Record Exh. F").

The first witness to testify was Brenda Pratt Shafer, a nurse who claimed to have worked in Dr. Haskell's office. Shafer testified that she observed an intact D & E procedure where a 26-week fetus visibly struggled during the procedure. Dr. Haskell's office submitted a letter in response stating that they do not perform intact D & E procedures after 24 weeks and noting other inconsistencies in Shafer's testimony. Certain senators also noted that Shafer's deposition testimony had previously been ruled inadmissible in Ohio's litigation concerning a state ban on intact D & E. Record Exh. F at 17-21, 205-06.

Next, the Senate heard from the first panel of witnesses, which included: Dr. Smith and Dr. Robinson, who had previously testified before the House; Dr. Mary Campbell, Dr. Nancy Romer, Dr. Norig Ellison, and Helen Alvare. Dr. Smith and Dr. Romer, who supported a ban on intact D & E, discussed generally the dangers of intact D & E and the lack of medical necessity for the procedure. Dr. Romer indicated that she had never performed an intact D & E.

Dr. Campbell, the medical director for the Washington DC Planned Parenthood affiliate, discussed

in general how second trimester abortions are performed, and Dr. Robinson reiterated his belief that Congress should not legislate how doctors practice medicine. Dr. Ellison, an anesthesiologist, offered testimony solely on the issue of whether anesthetic given to the woman would cause fetal demise, and he testified that it would not. Alvare offered testimony as a representative of the Catholic church that intact D & Es were immoral. The witnesses did not explain matters in great scientific detail, though they were questioned extensively on policy issues by the committee members and some medical research issues were discussed in that context. Record Exh. F at 75- 158.

The next panel of witnesses consisted of three women, two of whom had undergone intact D & Es: Coreen Costello, Viki Wilson, and Jeannie French. Costello was carrying a fetus diagnosed at seven months with a fatal neurological anomaly and needed to terminate the pregnancy. She had requested a caesarean but her doctors advised against the risk, and she could not undergo an induction because the fetus was suffering from hydrocephaly. She underwent an intact D & E, believed that the fetus had died before birth, and was able to hold the baby after the procedure. Wilson testified that her fetus was diagnosed at 36 weeks with an encephalocoele, where the brain develops outside the fetal skull, and would not live outside the uterus. Because of the size of the head, Wilson could not undergo an induction, and thus underwent an intact D & E. French testified that she gave birth to twins, one of whom was diagnosed with an encephalocoele and did not survive, and that intact D & E was not necessary for her. Record Exh. F at 158-168.

The third panel consisted of two law professors who debated the constitutionality of a ban, Record Exh. F at 169-207, and the remainder of the hearing materials consist of written statements from various doctors, medical associations, and pro-life advocacy groups. *Id.* at 207-363.

House Hearings on Anesthesia

The third and final hearing of the 104th Congress, held on March 21, 1996, focused on the issue of whether anesthesia given to the mother in an intact D & E would cause fetal demise.[43] Effects of Anesthesia During a Partial-Birth Abortion: Hearing before the Subcomm. on the Constitution of the House Comm. on the Judiciary, 104th Cong. 2nd Sess (1996) ("Record Exh. E").

In previous hearings, some doctors, patients, and pro-choice advocacy groups had indicated that they believed that the anesthetic given to a woman undergoing an intact D & E would be sufficient to cause fetal demise before the extraction procedure began. Record Exh. E at 1-3. A congressman who is also a doctor, Tom Coburn, testified that it would not. *Id.* at 135-136.

Next, a panel of four anesthesiologists provided testimony: Dr. Ellison, who had testified previously, Dr. David Birnbach, Dr. David Chestnut, and Dr. Jean Wright. All four doctors testified that anesthetic given to the mother would not cause fetal demise, and Dr. Wright testified that beginning around 26 weeks after gestation (28 weeks lmp) fetuses can feel intense pain.

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[43] Plaintiffs in this matter agree with the government that the anesthetic given to women will not cause fetal demise, and thus this question is not an issue in this litigation.

Record Exh. E at 137-150. The panel was then questioned by various members of Congress. *Id.* at 291-303.

The final panel consisted of Shafer, who had previously testified before the Senate; Costello, who had previously testified before the Senate, Mary-Dorothy Line, who had undergone an intact D & E, and Alvare, who had previously testified before the Senate. Shafer reiterated her testimony from the first hearing, as did Costello and Alvare. Line, who had not previously testified, stated that her fetus had been diagnosed as hydrocephalic at 22 weeks, and she had undergone an intact D & E where a needle was used to aspirate the fluid from the fetus' head. Record Exh. E at 310-335. Members of Congress then questioned the witnesses. *Id.* at 335-352.

The remainder of the record of this hearing consists of letters from advocacy groups and doctors, a letter from President Clinton opposing the ban, excerpts from previous portions of the Congressional Record before the Senate Judiciary Committee, medical research articles on fetal pain, a letter from Dr. Creinin, who testified before this court, stating that fetuses do not feel pain, and a copy of the order from the Ohio district court finding the Ohio ban on intact D & E unconstitutional. *See, e.g.*, Record Exh. E at 4-134, 151-282, 352-56.

The proposed bill was then passed by both chambers of Congress, and President Clinton vetoed it on April 10, 1996. 142 Cong. Rec. H3338 (daily ed. Apr. 15, 1996). The Senate was unable to override the veto, and it was sustained. 142 Cong. Rec. S11389 (daily ed. Sept. 26, 1996).

ii. 105th Congress

New legislation to ban intact D & E was then proposed in the 105th Congress. The House and Senate Judiciary Committees held a joint hearing on March 11, 1997, on the issue. Partial-Birth Abortion: The Truth: Joint Hearing on S. 6 and H.R. 929 before the Senate Comm. on the Judiciary and the Subcomm. on the Constitution of the House Comm. on the Judiciary, 105th Cong. 1st Sess (1997) ("Record Exh. D").

The first panel to testify at this hearing consisted of members of various advocacy groups: Renee Chelian, of the National Coalition of Abortion Providers; Kate Michelman, of NARAL; Helen Alvare, of the Catholic Church; Gloria Feldt, of Planned Parenthood; Vicki Saporta, of NAF; and Douglas Johnson, of the National Right to Life Committee. The witnesses presented primarily policy-based reasons for their positions, and not medical ones; some statistics on both sides were introduced into the record, but not discussed. Record Exh. D at 17-66. Members of Congress then extensively questioned the panel. *Id.* at 67-119.

The second panel consisted of Dr. Cook, who testified before this court, and is one of the co-founders of Physicians' Ad-Hoc Coalition for Truth ("PHACT"), a group opposed to intact D & E; Eileen Sullivan and Maureen Britell, who underwent intact D & Es; and Whitney Goin, whose fetus was diagnosed with fetal anomalies but who declined an abortion. Dr. Cook testified that there was no need for intact D & E but did not explain the medical reasons for his conclusions. Sullivan's fetus was diagnosed with a fatal heart anomaly at 26 weeks, and Sullivan decided on an intact D & E so the fetus could be autopsied to help her in making her future reproductive decisions. Britell, who was pre-

viously active in the pro-life movement, was pregnant with a fetus diagnosed with anencephaly at the beginning of her third trimester. When Britell's induction abortion failed, she underwent an intact D & E so her priest could deliver religious rites to the fetus. Goin's fetus was diagnosed with abdominal defects which were not fatal but would require extensive surgery after birth. Goin declined a second trimester abortion and her child is alive today. Members of Congress questioned the women and Dr. Cook whether intact D & E procedures were necessary in their circumstances. Record Exh. D at 120-135.

The remainder of the record consists of prepared statements by attorneys on the issue of the constitutionality of the bill, copies of medical research articles, copies of previous testimony given before Congress on the issue, and letters from advocacy groups. *See, e.g.*, Record Exh. D at 1-17, 135-142, Record Appendix.

The bill was passed, and President Clinton vetoed it. 143 Cong. Rec. H8891 (daily ed. Oct. 21, 1997). The Senate was again unable to override the veto. 144 Cong. Rec. S10564 (daily ed. Sept. 18, 1998).

iii. 106th Congress

No hearings were held in the 106th Congress, but other written materials were introduced into the Congressional Record, such as letters from doctors and policy groups.

The Supreme Court decided *Stenberg* on June 28, 2000, and relied in part on evidence presented in the Congressional Record up to this point.

iv. 107th Congress

On July 9, 2002, Congress again held a hearing on the issue of intact D & E. Partial Birth Abortion Ban Act of 2002: Hearing before the Subcomm. on the Constitution of the House Comm. of the Judiciary, 107th Cong. 2nd Sess (2002) ("Record Exh. C").

The only panel of witnesses that testified at this hearing consisted of Dr. Aultman and Dr. Cook, both of whom supported the ban and had previously testified before Congress; Simon Heller, an attorney on behalf of the Center for Reproductive Law and Policy who believed the proposed law to be unconstitutional; and Robert Destro, an attorney who believed the proposed law to be constitutional. Dr. Aultman testified that the bill was not vague and that no health exception was needed, and Dr. Cook testified that intact D & E was not medically necessary. Dr. Aultman also provided a position paper outlining the medical basis for her opinion. Heller and Destro presented opposing views on the constitutionality of the ban. Record Exh. C at 6-28. Members of Congress then questioned the witnesses. *Id.* at 28-46.

The record also includes an extensive appendix of materials, which includes letters from doctors and advocacy groups, statements from senators, and medical papers on both sides of the issue. Record Exh. C at 47-280.

v. 108th Congress

The House held its final hearing on this issue on March 25, 2003. Partial-Birth Abortion Ban Act of 2003: Hearing before the Subcomm. on the Constitution of the House Comm. on the Judiciary, 108th Cong. 1st Sess (2003) ("Record Exh. B").

Only one panel of witnesses testified at this hearing, consisting of Dr. Mark Neerhof, who supported a ban, and Simon Heller and Gerard Bradley, attorneys testifying regarding the constitutionality of the act. Dr. Neerhof provided an overview of his medical opinion concerning the lack of necessity for the procedure. The Congressional Findings of Fact appear to have drawn in significant part from this overview. Record Exh. B at 6-10. Heller and Bradley discussed the constitutionality of the act in light of *Stenberg*, and Bradley's conclusions appear to have been incorporated into the Congressional Findings of Fact as well. *Id.* at 10-22. Members of Congress then questioned the witnesses. *Id.* at 22-35.

The record of this hearing also includes an extensive appendix, consisting of statements from doctors and policy groups on both sides of the issue. Record Exh. B at 37-279.

b. Analysis re: Congressional Record

i. Witnesses

The oral testimony before Congress was heavily weighted in favor of the Act. As was the case with many of the government's witnesses before this court, Congress heard disproportionately from physicians opposed to abortion generally, unless the life of the mother was absolutely compromised. This court's review of the Congressional Record reflects that over a period of approximately eight years, Congress entertained live testimony from a total of eight physicians, six of whom supported the ban, and two of whom

opposed the ban.[44] Of those six physicians who supported the ban, two are related to the instant case: Drs. Cook and Neerhof. Like the government's witnesses in this case, none of the six physicians who testified before Congress had ever performed an intact D & E. Several did not provide abortion services at all; and one was not even an obgyn.

It is apparent to this court, having heard the testimony of the thirteen expert witnesses in this case, and having reviewed the deposition testimony of an additional six expert witnesses, that the oral testimony before Congress was not only unbalanced, but intentionally polemic. In contrast to the evidence before Congress, this court heard from eight physicians who have all performed the banned procedure, and have been instructed in the procedure, many of whom teach the procedure themselves.

This court cannot evaluate the credibility of those witnesses who appeared both before this court and also testified or submitted materials to Congress *as they appeared before Congress.* However, this court has made findings regarding those witnesses' credibility, set forth above, *as they appeared before this court.* That group includes Drs. Cook, Sprang, and Bowes.

While Dr. Sprang did not testify personally before Congress, he submitted letters in favor of the ban, and along with Dr. Neerhof, who testified before Congress in support of a ban, is the co-author of an article submitted to and cited by Congress in support of its findings. See Exh. A-55, Sprang & Neerhof, *Rationales*

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[44] This does not include the four physicians who testified exclusively regarding the effect of maternal anesthesia on the fetus, not at issue here.

for Banning Abortions Late in Pregnancy, 280 Journal of the American Medical Association ("JAMA") 8, at 744-47 (August 26, 1998). Many of the congressional "findings" mirror substantially the conclusions reached in Dr. Sprang's article. That article, upon which Congress very obviously relied, and which was admitted into evidence at trial, was published in 1998, prior to the Supreme Court's decision in *Stenberg*, and was considered and implicitly rejected by the Supreme Court in its decision. *See* 530 U.S. at 933, 120 S. Ct. 2597 (citing to article).

This court finds a number of the conclusions in that article, including those resembling many of Congress' findings, troublesome and contrary to the medical evidence presented by both sides to this court. The article itself constitutes an opinion piece, representing a generally anti-late-term abortion view. The article was published in the "Controversies" section of the journal, a section that includes "one article pro and one article con on an issue." Dr. Sprang himself agreed that the article was one part of a two-part piece taking opposite viewpoints on restrictions on late-term abortions. Tr. Vol. 7 at 1020:19-23; 1032:17-19 (Sprang).[45]

Unlike other studies that this court admitted into evidence, the article did not rely on any clinical research or medical studies conducted by Dr. Sprang. Instead, it was based on his review of the literature on the issue—literature which included non-medical sources like newspaper articles and weekly periodicals. For that reason, this court indicated at trial that it

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[45] Dr. Sprang was asked to draft his article in response to an article by Dr. David Grimes, opposing restrictions on late-term abortion methods. *Id.* at 1020:17-25.

found the article itself to be lacking in trustworthiness. Tr. Vol. 8 at 1340:2-11 (Sprang). Moreover, given Dr. Sprang's lack of expertise in late-term abortion procedures, and intact D & E procedures specifically, and the contradictory testimony that Dr. Sprang gave at trial, the article and many of its conclusions become even more questionable.

This court shares similar qualification and credibility concerns regarding Dr. Cook, another government witness, based on his testimony before this court. Dr. Cook testified before Congress several times and also submitted written materials to Congress in opposition to the ban from himself, and from an organization that he co-founded, PHACT. Congress relied in part on Dr. Cook's testimony for its findings, testimony which included his opinion regarding two specific medical situations concerning the necessity of intact D & E.[46] Tr. Vol. 9 at 1437:13-20 (Cook).

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[46] Dr. Cook testified, however, that he did not review the actual medical records associated with the cases about which he testified. *Id.* at 1382:3-11. The two medical situations regarding which Dr. Cook opined before Congress were in rebuttal to a letter written by a physician, Dr. Phillip Darney, in opposition to the Act. In that letter, Dr. Darney detailed two specific situations for Congress in which he believed that the intact D & E procedure had been necessary to the life of the women. Dr. Cook responded, rebutting the necessity of the intact D & E procedure. *Id.* at 1437:13-20.

Government counsel posed the same two situations as hypotheticals to Dr. Cook before this court, both of which included women with placenta previa and other disorders or emergency circumstances requiring pregnancy termination. *Id.* at 1438:10-1441:14. Dr. Cook opined that intact D & E was neither necessary nor recommended. However, Dr. Chasen, in subsequent testi-

Both Dr. Bowes, who testified for the government, and Dr. Creinin, plaintiffs' witness, submitted letters to Congress in support of, and in opposition to the Act, respectively. However, this court does not have the same credibility concerns with respect to the government's witness, Dr. Bowes, or plaintiffs' witness, Dr. Creinin.

ii. Medical Organizations

Congress also had before it policy statements and materials from numerous medical organizations, the majority of which opposed the Act. Among the medical organizations who submitted materials in opposition to the Act were ACOG, CMA, AMWA, NAF, APHA, PRCH ("Physicians for Reproductive Choice and Health"), and ANA ("American Nurses Association"). Two organizations supporting the bill also submitted materials: PHACT, co-founded by Dr. Cook, and AAPS. As noted, the AMA, which supported a ban initially, subsequently withdrew its support.

In the materials submitted before Congress, the two largest medical organizations, ACOG and AMA, while agreeing in their opposition to the Act, disagreed regarding their positions on "partial-birth abortion." The AMA was ethically opposed to "partial-birth abortion," whereas ACOG believes that there are circumstances during which "partial-birth abortion" "may be the most appropriate and safest procedure to save the life or health of a woman." *See* Record Exh. B, at 146-152 (1997 AMA "Fact Sheet"); Record Exh. C, at 186 (AMA Statement); *id.* at 260 (AMA Policyfinder); *Id.* at 240 (4/00 ACOG "Fact Sheet"); Record Exh. B, at 197

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mony, disagreed with Dr. Cook's opinions. *See* Tr. Vol. 11 at 1768-1782 (Chasen).

(7/02 ACOG Statement). In recognition of their differences, the AMA and ACOG submitted to Congress a "Joint Statement," noting that "they were concerned regarding the negative impact caused by different positions reached by [the organizations]," and provided goals common to both organizations. *See* Record Exh. C, at 220 (AMA/ACOG Joint Statement). One commonality shared by both ACOG and the AMA was that they opposed any partial-birth abortion ban that included criminal sanctions. *Id.*

Congress in its findings, however, chose to disregard the statements by ACOG and other medical organizations in opposition to the Act, and then exclusively utilized statements derived directly from 1997 AMA policy statements in its findings—policy statements that the Supreme Court had before it in *Stenberg*, but did not rely upon in reaching a contrary conclusion.[47] *See Stenberg*, 530 U.S. at 934-35, 120 S. Ct. 2597 (noting 1997 AMA policy statement asserting that "there does not appear to be any identified situation in which intact [D & E] is the only appropriate procedure to induce abortion"). Among the statements that Congress disregarded was ACOG's amicus brief submitted to the Supreme Court in *Stenberg*, and cited by the Supreme Court approvingly in that case,[48] and a July 2002 ACOG

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[47] All of the quotations attributed to a "prominent medical association" in the Congressional findings refer to statements made by the AMA, primarily in its Fact Sheet issued June 1997. *See* Act § 2(14)(C), (I); *see also* Record Exh. B, at 146-152.

[48] Citing to ACOG's amicus brief filed in that case, the Supreme Court rejected the defendant's mischaracterization of ACOG's position on intact D & E. Specifically, the Court noted ACOG's reasoning regarding why intact D & E may be the most appropriate and safest abortion procedure under certain circum-

statement, one of the few new statements submitted by a medical organization post-*Stenberg*. *See* Record Exh. A, at 98 (ACOG amicus brief); Record Exh. B, at 197 (7/02 ACOG statement). That statement provides in pertinent part that:

> ACOG has concluded that there are circumstances under which this type of procedure would be the most appropriate and the safest procedure to save the life or health of a woman. Only the doctor, in consultation with the patient, based upon the woman's particular circumstances, can make this decision.
>
> This bill violates a fundamental principle at the very heart of the doctor-patient relationship; that the doctor, in consultation with the patient, based on the patient's individual circumstances, must choose the most appropriate method of care for the patient. This bill removes decision-making about medical appropriateness from the physician and the patient. ACOG's members, whatever their beliefs about abortion, share an interest in opposing laws that interfere with a physician's ability to exercise his or her best medical judgment in providing care for each patient.
>
> ACOG opposes legislation such as HR 4965 as inappropriate, ill-advised and dangerous intervention into medical decision-making. HR 4965 is vague and broad, with the potential to restrict other techniques in obstetrics and gynecology. It fails to use recognized medical terminology and fails to define

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stances, and safer than the alternatives. *See Stenberg*, 530 U.S. at 936, 120 S. Ct. 2597.

> explicitly the prohibited medical techniques it criminalizes. ACOG notes particularly that imposing criminal penalties for use of a procedure that includes elements of recognized gynecologic and obstetric techniques could outlaw use of those techniques in both abortion and non-abortion circumstances. Some of these techniques can be critical to the lives and health of American women.

Record Exh. B, at 197.

iii. Congressional Debate

The Act itself and especially the Act's ultimate finding that "partial-birth abortion is never medically indicated to preserve the health of the mother," were hotly contested within Congress. *See generally, e.g.*, Record Exh. A, at 147-154 (dissenting views signed by fourteen legislators). Dissenting legislators opposed the Act on numerous grounds, both legal and policy-based, including that: (1) the Act unconstitutionally omits an exception to protect maternal health; (2) that the Supreme Court will not defer to erroneous factual and legal conclusions masked as congressional "findings;" (3) the threat to the separation of powers; (4) the Act's overbreadth and undue burden on a woman's right to obtain an abortion; (5) the danger to women's health posed by the Act's ban on safe abortion procedures; and (6) the criminalization of doctors and the conflict the Act encourages between pregnant women and their husbands, or in the case of minors, their parents. *Id.*

Opponents of the Act argued before Congress that the Act was both legally unsound and a mischaracterization of abortion procedures. Opponents contended that:

> This bill as written fails every test the Supreme Court has laid down for what may or may not be a constitutional regulation on abortion. . . . While . . . proponents of this bill view all abortion as tantamount to infanticide, that is not a mainstream view. This bill attempts to foist a marginal view on the general public by characterizing this bill as having to do only with abortions involving healthy, full-term fetuses. If the proponents of this bill really want to deal with post-viability abortions in situations in which a woman's life and health are not in jeopardy, then they should write a bill dealing with that issue.

Record Exh. A, at 73-74.

Moreover, Congress debated and ultimately rejected an amendment that would have added a health exception to the Act. *Id.* at 27, 65. Arguing in favor of a health exception, opponents asserted that:

> [T]he families that are affected by this bill are dealing with the tragic circumstances of crisis pregnancies. In most cases, they have just learned that their babies will not survive. They are then confronted by choices that none of us would wish on any human being. This is the context in which . . . this legislation comes into play. And any suggestion to the contrary deceives the American public about the realities of this issue.
>
> . . . .
>
> Typically, women who must face this decision want nothing more than to have a child and are devastated to learn that their baby would not survive outside the womb. In consultation with their

> doctors and families, they make difficult decisions to terminate pregnancies to preserve their own health, and in many cases to preserve their ability to have children in the future.

Id. at 69-70.

iv. Comparison with *Stenberg* Record

In support of its conclusion that "partial-birth abortion" is never necessary, Congress asserted, and the government has argued, that following the courts' decisions in *Stenberg*, Congress had evidence available to it that was not available at the time *Stenberg* was decided. In its findings, Congress stated:

> [O]verwhelming evidence presented and compiled at extensive congressional hearings, *much of which was compiled after the district court hearing in Stenberg,* and thus not included in the *Stenberg* trial record, demonstrates that a partial-birth abortion is never necessary to preserve the health of a woman, poses significant risks to a woman upon whom the procedure is performed, and is outside the standard of medical care.

Act, § 2(5) (emphasis added). However, this court's review of the Congressional Record reveals that the opposite is true.

Although Congress utilized the *Stenberg* district court's decision from July 1998, as the benchmark regarding the status of the medical evidence on the issue, the real benchmark must be the Supreme Court's decision in *Stenberg*, which was issued on June 28, 2000. As noted, the district court record was just one of the "medically related evidentiary circumstances" supporting the Supreme Court's determination that a

health exception was required. *Stenberg*, 530 U.S. at 936-37, 120 S. Ct. 2597. The Supreme Court considered also the division of opinion among medical experts and the state of medical studies that *existed at the time the Supreme Court decided Stenberg*—including the Congressional Record to date and numerous amicus briefs submitted by interested parties. *Id.* at 933-36, 120 S. Ct. 2597.

However, regardless of which benchmark is utilized—the *Stenberg* district court's decision in 1998, or the Supreme Court's decision in June 2000—this congressional finding is inaccurate and contrary to the very record that existed before Congress. The majority of congressional hearings and evidence were conducted before and collected by the 104th and 105th Congresses from 1995-1997, prior to both the district court's and the Supreme Court's decisions. Following the district court's decision in *Stenberg* in 1998, Congress held only two hearings on the intact D & E procedure. None of the testimony received by Congress at those hearings can reasonably be considered "new" medical evidence not available to the courts at the time *Stenberg* was decided.[49]

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[49] Of the three physicians who testified before Congress regarding the proposed ban and the necessity or safety of the procedure, all three offered positions supporting the ban. Two of the three included Dr. Cook, who testified before this court, and Dr. Neerhof, the physician who co-authored the pre-*Stenberg* 1998 article relied on by Congress extensively for its findings. Moreover, two of the three, Dr. Cook and Dr. Aultman, had testified prior to the *Stenberg* decision. Dr. Neerhof, who had not testified previously, offered testimony that mirrored the Sprang/Neerhof article published in 1998.

Outside of the *Stenberg* record, which included the amicus briefs considered by the Supreme Court, several medical organizations, including ACOG, APHA, PRCH, and AMWA, submitted new materials in opposition to the Act. PHACT, the organization co-founded by Dr. Cook, also submitted new material in support of the Act. Additionally, there were numerous letters from physicians and other interested individuals both in support of and in opposition to the Act. However, review of these documents and materials confirms that there was no new medical evidence before Congress, and that the post-*Stenberg* submissions simply reiterated the same arguments and positions that Congress had before it prior to the courts' decisions in *Stenberg*.

Accordingly, based on the record before this court and a review of the Congressional Record, this court finds that at the time that it made its findings, Congress did not have before it any *new* medical evidence or studies not available to both the district court and Supreme Court in *Stenberg*, at the time that the courts issued their decisions.

c. Specific Congressional Findings

As noted, in support of its conclusion that the partial-birth abortion procedure is never necessary to preserve the health of the mother, Congress also made numerous other findings at sections 14(A) through (O). *See* Act, § 2(14)(A)-(O). These findings include Congress' more specific or particular factual findings pertinent to its ultimate conclusion. Many of these findings were also disputed within Congress.[50]

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[50] Congress rejected an amendment to strike the congressional findings of fact. *See* Record Exh. A, at 29. Proponents of the amendment argued that:

In support of its argument that this court must defer to Congress' determination that the procedure is never medically necessary, the government argues that Congress' finding is reasonable because "numerous express findings" support its "considered judgment" or ultimate finding that the procedure is never necessary. However, based on the evidence before this court, which includes the Congressional Record, and this court's review of Congress' specific findings in support of its conclusion, this court finds that Congress' conclusion that the procedure is never medically necessary is not reasonable and is not based on substantial evidence.

The individual findings, which Congress and the government contend support deference to Congress' ultimate finding, tend to fall into one of two categories: (1) the findings are factually wrong; or (2) there is a split in the medical evidence regarding the particular issue, and Congress has chosen a position. With respect

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> [M]any of the findings are incorrect and inaccurate. As we have already discussed, the majority of medical evidence indicates that intact D & E . . . procedure is a safe abortion procedure and may be the safest option for some women. . . . It's not just these medical experts who believe that [intact D & E] is a safe and effective procedure that is most appropriate in certain cases, [but] [t]he United States Supreme Court came to the same decision in *Stenberg v. Carhart*. . . . The findings in this bill simply ignore the significant evidence of medical experts and the reasoned judgment of the Supreme Court. . . . The second reason to remove these findings is that they are not supported by any sort of legislative record. These findings, which are identical to last year's bill, were drafted and introduced before the Constitution Subcommittee even had a legislative hearing to establish any case to justify the bill. Talk about putting the cart before the horse.

Id. at 83-84.

to this latter category, there are, however, several findings that are legally irrelevant to the necessity of a health exception, as discussed in this court's conclusions of law below.

It is noteworthy that all of the government's own witnesses disagreed with many of the specific congressional findings. In particular, Dr. Bowes, who had submitted several letters to Congress in support of a ban and one of the government witnesses whom this court found particularly credible, disagreed not only with particular findings, but with Congress' ultimate finding that:

> Partial-birth abortion remains a disfavored procedure that is not only unnecessary to preserve the health of the mother, but, in fact, poses serious risks to the long-term health of women, and in some circumstances their lives.

Act, § (2); see Tr. Vol. 6 at 975: 1-8 (Bowes).[51]

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[51] Dr. Bowes, testified that he disagreed with this congressional finding, and asserted that it was his view that "no valid scientific evidence support[ed] the finding." *Id.* at 975:9-11. Dr. Bowes asserted that no one in Congress "sought his opinion whether [he] thought the findings in the bill were accurate," and that if they had, he would have advised Congress that "they were not accurate." *Id.* at 986:5-11. Moreover, he noted that his support for the Act is not "based on any concerns for protecting maternal health" because he does not "think that those have been established." *Id.* at 976:8-11. Instead, his "support for the Act is based on [his] ethical opposition to abortion in general," and his "ethical opposition to abortion procedures previability is not in any way particular to the intact D & E procedure as opposed to other methods of abortion." *Id.* at 976:17-21.

i. *Alleged Consensus of Opinion Regarding Procedure*

In support of its ultimate finding, Congress found that "[a] moral, medical, and ethical consensus exists that the practice of performing a partial-birth abortion . . . is a gruesome and inhumane procedure that is never medically necessary and should be prohibited." Act § 2, (1). This particular finding resembles the assertion in the Sprang/Neerhof article that "[a]n extraordinary medical consensus has emerged that intact [D & E] is neither necessary nor the safest method for late-term abortions," and the article's reference to the procedure as "needlessly inhumane." Exh. A-55, at 745.

However, the evidence available to Congress in passing the Act in 2003, and currently before this court, very clearly demonstrates the opposite: that there is no medical or ethical consensus regarding either the humanity, necessity, or safety of the procedure. Instead, the same division of opinion among physicians and the relevant ethical groups exists today as existed when *Stenberg* was decided. There is no consensus that intact D & E, which this court has found is a variant of the D & E procedure, is any less humane than other surgical abortion procedures. Nor is there a consensus regarding its safety or necessity.

Indeed, Congress' very findings contradict its assertion that there is a consensus. Congress subsequently noted in its findings that "a prominent medical association," the AMA, concluded that "there is no consensus among obstetricians about" the use of intact D & E. *See* Act, § 2(14)(C) (citing AMA Fact Sheet 6/97). In fact, there was no consensus even within the AMA itself regarding the procedure. *See* Tr. Vol. 7 at 1163

(Sprang) (agreeing that AMA task force did not reach a consensus regarding the ethics of intact D & E). As noted, Congress also had before it a joint statement from the AMA and ACOG, the two largest medical organizations taking positions on the issue, which recognized the disagreement among and within the two organizations. *See also* Record Exh. A, at 66 (opponents to the Act in Congress argued that the "medical community does not support banning partial-birth abortions," and cited to ACOG findings and sixteen medical organizations in addition to ACOG who oppose a ban).

Moreover, three of the four government witnesses that testified on the subject recognized that there was no consensus regarding the procedure. This included Dr. Sprang, who testified contrary to his 1998 article, and agreed that "there is a variation of opinion" among the medical community regarding whether intact D & E should be banned. Tr. Vol. 7 at 1170:6 (Sprang); *see also id.* at 1168:22-1169:1 (also agreeing that there is no ethical consensus among physicians and professors at Northwestern University, where he teaches and practices). Another government witness, Dr. Shadigian, further agreed that "there is no consensus in the medical community that the procedures banned by the [Act] are not safer for some women in some circumstances than other available procedures." Tr. Vol. 8 at 1297:18-24 (Shadigian). She testified that "responsible physicians could reach different conclusions as to the medical appropriateness of banning the procedures covered by the Act." *Id.* at 1297:12-17; *see also* Tr. Vol. 6 at 960:13-22 (Bowes) (agreeing that "there is a body of medical opinion which consists of [a] responsible group of physicians that hold the opinion that intact removal of a fetus

during a surgical abortion may be the safest procedure for some women in some circumstances"); *see also* Cain Depo. 37:12-22; 220:14-222:21; 234:20-235:12; Exh. 14 (noting that ACOG's Executive Board reaffirmed the group's January 1997 policy statement regarding "partial-birth abortion" and that it remains the policy of ACOG today); Kissell Depo. Exh. 41, 42, 43 (AMWA position); Baker Depo. Exh. 5 (APHA position); Whitelaw Depo. Exh. 70 (CMA); CMA Amicus Brief.

ii. *Current Medical Practice Regarding Intact D & E*

Additionally, Congress found that "particularly among physicians who routinely perform other abortion procedures, partial-birth abortion remains a disfavored procedure . . . [within] the medical community" and asserted that it "is in fact unrecognized as a valid abortion procedure by the mainstream medical community." Act, § 2(2); 14(O).

Congress appears to have based this finding on the testimony of a few physicians who themselves never perform intact D & E procedures. However, as demonstrated both by the lack of consensus in the medical community as discussed above, and by twelve of the plaintiffs' witnesses before this court who routinely perform abortion procedures at highly-respected institutions, this finding is simply inaccurate. Several of plaintiffs' witnesses were, in the course of caring for their patients, performing intact D & E procedures at the time Congress conducted its hearings and was gathering evidence regarding intact D & Es. *See, e.g.*, Tr. Vol. 2 at 187:15-19 (Sheehan); Tr. Vol. 4 at 584:16-585:3 (Broekhuizen). Had Congress attempted to obtain an opinion from "physicians who routinely perform

other abortion procedures," it would have learned that this was the case.

Moreover, among the government experts that testified, it is apparent that it is not just intact D & Es that they disfavor. Those experts who disfavored intact D & E, which included all of the government's witnesses, tend to disfavor elective abortion generally and *all* D & E procedures, whether intact or by disarticulation.

Among these are Dr. Cook and Dr. Sprang. As noted, Dr. Cook's preference for induction over D & E, intact or by disarticulation, is so strong that there are circumstances under which Dr. Cook would utilize induction, or an even less safe alternative, hysterotomy, when the medical evidence and literature suggests that the safest procedure is D & E. *See, e.g.*, Tr. Vol. 6 at 972:6-8 (Bowes) ("in most cases an intact D & E would be preferable to a hysterotomy").

Dr. Sprang attested that his ethical objections could be extended to any D & E, and even to an induction abortion in which a fetus was delivered partially, and having become lodged in the mother's cervix, was subject to demise outside the body of the mother. Tr. Vol. 7 at 1165:10-15 (Sprang). He asserted that his ethical objections "were not limited to intact D & E, but to any situation where the act that killed the fetus occurred outside of the body of the mother." *Id.* Dr. Shadigian and Dr. Bowes likewise testified that they did not find intact D & E any more objectionable than D & E in general. Tr. Vol. 8 at 1303:25-1304:12 (Shadigian); Tr. Vol. 6 at 976:17-21 (Bowes).

iii. *Alleged Complications Associated with Intact D & E*

Congress further found that intact D & E "poses serious risks to the long-term health of a woman and in some circumstances, their lives." Act, § 2(2); 14(A). Again, this finding is very similar to the Sprang/Neerhof article, which concludes that "intact [D & E] poses serious medical risks to the mother." Exh. A-55, at 744. The specific risks listed by Congress mirror those listed in the article:

> (1) an alleged risk of cervical incompetence, a result of cervical dilation making it difficult or impossible for a woman to successfully carry a subsequent pregnancy to term;
>
> (2) an increased risk of uterine rupture, abruption, amniotic fluid embolus, and trauma to the uterus as a result of converting the fetus to a footling breach position, a procedure which, according to a leading obstetrics textbook, "there are very few, if any indications for other than delivery of a second twin";[52]
>
> (3) a risk of lacerations and secondary hemorrhaging due to the doctor blindly forcing a sharp

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[52] According to the Sprang/Neerhof article:

> An integral part of the [intact D & E] procedure is an internal podalic version, during which the physician. . . convert[s] the lie to a footling breech. The internal version carries risk of uterine rupture, abruption, amniotic fluid embolus, and trauma to the uterus. According to *Williams Obstetrics*, 'there are very few, if any indications for internal podalic version other than for delivery of a second twin.'

Exh. A-55, at 744.

instrument into the base of the unborn child's skull while he or she is lodged in the birth canal;[53]

(4) a risk [that the procedure described above in #3] could result in severe bleeding, bringing with it the threat of shock, and ultimately resulting in maternal death.[54]

See id. at 2(14)(A).

The risks described above, however, to the extent that they exist, are not specific to intact D & E, but instead may be present in any D & E, a procedure whose necessity and safety are not at issue because it is generally considered both necessary and safe. *See, e.g.*, Tr. Vol. 7 at 1148:4-6 (Sprang) (agreeing with AMA task force that it is unresolved whether these complications are more likely to result from D & E or intact D & E than from labor induction techniques). Moreover, this court has already found, based on medical evidence —evidence that was available to Congress at the time that it made its findings—that the government has not shown that intact D & E increases the likelihood of cervical incompetence, and that the risk of laceration caused by instrumentation or fetal bone fragments is

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[53] The Sprang/Neerhof article provides in pertinent part:

> The second potential complication of intact [D & E] is the risk of iatrogenic laceration and secondary hemorrhage. Following internal version and partial breech extraction, scissors are forced into the base of the fetal skull while it is lodged in the birth canal. This blind procedure risks maternal injury from laceration of the uterus or cervix by the scissors. . . .

Exh. A-55, at 745.

[54] The article continues, that the "blind procedure," quoted above, "could result in severe bleeding and the threat of shock or even maternal death." *Id.*

minimal and no greater than that associated with all D & E procedures.

Additionally, the evidence before this court demonstrated that abruption, the separation of the placenta from the uterus prior to birth, and amniotic fluid embolus, in which amniotic fluid enters the mother's blood stream via the placenta, resulting in a potentially lethal maternal infection, are not risks specific or relevant to an intact D & E. *See* Grunebaum Depo 198:11-22; 200:7-201:2; Tr. Vol. 4 at 669:20-671:8 (Creinin) (explaining that in an abortion, "separating the placenta from the uterus is an innate part of the D & E" and that it is irrelevant to the procedure when the placenta is removed); *Id.* at 673:5-675:17 (amniotic fluid embolus likewise irrelevant to D & E abortion because the amniotic fluid is removed at the beginning of the procedure); Tr. Vol. 5 at 827:19-829:1 (Westhoff). While the parties did not offer testimony at trial on the issue of whether intact D & E is more likely to cause maternal death, the court notes that abortion, generally, remains an extremely safe procedure in terms of mortality. Moreover, none of the physicians who testified before this court and who perform intact D & Es have had a patient die as a result of the procedure.[55]

iv. *Comparative Safety of Intact D & E*

Congress further found that "[t]here is no credible medical evidence that partial-birth abortions are safe or

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[55] Additionally, Chasen's study, completed following the congressional findings, preliminarily indicated that the intact D & E method led to fewer major health complications than D & Es by disarticulation, which leads to the inference that the death rate for intact D & E would be lower as well.

are safer than other abortion procedures." Act. § 2, 14(B). In support Congress asserted that:

> (1) No controlled studies of partial-birth abortions have been conducted nor have any comparative studies been conducted to demonstrate its safety and efficacy compared to other abortion methods;[56]
>
> (2) there have been no articles published in peer-reviewed journals that establish that partial-birth abortions are superior in any way to established abortion procedures;
>
> (3) there are currently no medical schools that provide instruction on abortions that include the instruction in partial-birth abortions in their curriculum.[57]

See id. at § 2, (14)(B).

However, for the reasons discussed above in this court's findings, the trial evidence in this case demonstrates that the intact D & E procedure is as safe as D & E, and under some circumstances, is safer.

Even the government's witnesses, including Dr. Sprang, testified that there is no medical proof that intact D & E is less safe. *See* Tr. Vol. 7 at 1167:23-24 (Sprang) (agreeing that there is no absolute proof that

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[56] The Sprang/Neerhof article states: "There exist no credible studies on intact [D & E] that evaluate or attest to its safety." Exh. A-55, at 744.

[57] Again, Congress appears to have taken this at least in part from the Sprang/Neerhof article which asserts that the intact D & E "procedure is not recognized in medical textbooks nor is it taught in medical schools or in obstetrics and gynecology residencies." *Id.*

intact D & E is less safe than D & E generally); *see also* Tr. Vol. 9 at 1486:22-1487:5 (Cook) (agreeing that with respect to instrumentation, "when comparing D & E with intact D & E at the same gestational age, there appear to be some benefits to intact D & E"); Tr. Vol. 8 at 1293:1-3; 1298:4-7 (Shadigian) (agreeing that "there is no basis in the literature to prove that [intact D & E] is less safe" and that the necessity of a procedure is not the same thing as its safety).

Government witness Dr. Bowes testified that it has been established that "overall D & E is a safer procedure than induction." Tr. Vol. 6 at 946:5-7 (Bowes). Moreover, he noted that he was "not aware of any evidence-based medicine that establishes that the removal of the fetus intact during the D & E is less safe than a D & E with disarticulation." *Id.* at 971:14-17; 972:9-13 (agreeing also that "there is no reliable medical basis upon which to say that intact removal of a fetus during a D & E is any more dangerous to a woman than any other abortion method"). Dr. Bowes further agreed that "intuitively, it is safer if the fetus can be removed with fewer instrumental passes" and generally that, intact D & E may be safer for this reason. *Id.* at 944:21-25.

Absence of Controlled Studies or Peer-Reviewed Articles

As was the case at the time the Supreme Court decided *Stenberg*, there was a similar absence of studies or peer-reviewed articles at the time that Congress made its findings regarding the comparative safety of intact D & E.[58]

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[58] However, as noted above in this court's findings, since the enactment of the Act, the Chasen study, a historical cohort study

However, the court notes, based on the Supreme Court's decision in *Stenberg*, that the absence of studies does not support Congress' ultimate finding that the procedure is never necessary or that a health exception is never necessary. Instead, the Supreme Court specifically held that the "absence of controlled medical studies that would help answer these medical questions" was one of the "medically related evidentiary circumstances," which led it to conclude that the Nebraska law "requires a health exception." *Stenberg*, 530 U.S. at 937, 120 S. Ct. 2597.

Medical School Instruction/Curriculum

Congress appears to have based its erroneous conclusion that "there are currently no medical schools that provide instruction on abortions that include the instruction of partial-birth abortions in their curriculum" on the testimony of one of the witnesses in the *Stenberg* case. *See* Act, § 2(14)(B).

Based on the evidence available to this court, the intact D & E procedure is taught at several major medical schools, including those that are a part of New York University, Columbia University, Cornell University, Albert Einstein College of Medicine, Northwestern University, UCSF, UCSD, and the University of Pittsburgh, and is performed at some of the leading medical institutions in the country, including the hospitals associated with those universities. Tr. Vol. 5 at 795:15-22; 805:1-6; 830:10-832:6 (Westhoff) (the pro-

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comparing the safety of D & E with intact D & E has been accepted for publication by a leading peer-reviewed obgyn journal. Government witness Dr. Bowes agreed "that a study like Dr. Chasen's is often the first step in the process towards a randomized controlled trial." Tr. Vol. 6 at 961:5-8 (Bowes).

cedure "lies within the standard of medical care" as it is taught and performed safely at "a number of . . . university-based abortion services" and is "widely accepted among academically-based abortion providers"). Moreover, intact D & E is discussed in authoritative medical texts, including those authored or co-authored by Drs. Paul and Westhoff. *See, e.g.* Tr. Vol. 6 at 950:16-24 (Bowes) (agreeing that Dr. Paul's abortion textbook is authoritative and that Westhoff's reputation was high in the obgyn community).

Accordingly, because there are circumstances in which intact D & E may be the safest procedure, contrary to the congressional finding otherwise, a ban on intact D & E does not promote or advance the health interest of pregnant women seeking to terminate a pregnancy. The opposite is true because the Act, as written, may force pregnant women to undergo a procedure that is less safe under their particular circumstances.

v. *Characterization of Intact D & E as "Infanticide"*

Congress also found that the ban "will draw a bright line that clearly distinguishes between abortion and infanticide." Act, § 2(14)(G). It found that intact D & E constitutes "the killing of a child that is in the process, in fact mere inches away from becoming a 'person.'" *See id.* at § 2(14)(H). Congress further analogized the procedure to the "killing of a newborn infant," and asserted that the "vast majority of babies killed during partial-birth abortions are 'alive' until the end of the procedure." *See id.* at § 2(14)(L), (M).[59]

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[59] Again, these "findings" were undoubtedly derived in part from the Sprang/Neerhof article, which provides in pertinent part:

However, what the congressional findings omit, as discussed, is that the Act applies regardless of gestational age or viability. It is not disputed in this case that the "newborn infant" or "baby" "mere inches away from being born," as referred to by Congress, and with respect to all of the intact D & E procedures at issue in this case, *is not viable*, meaning that the fetus would be unable to survive outside of the mother. Tr. Vol. 1 at 74:14- 80:20 (Paul); Tr. Vol. 1 at 165:7-21 (Sheehan); Tr. Vol. 2 at 281:15-21 (Drey); Tr. Vol. 3 at 420:9-22(Doe); Tr. Vol. 4 at 550:18-552:9 (Broekhuizen); Tr. Vol. 4 at 657:3-8 (Creinin); Tr. Vol. 5 at 822:9-824:2 (Westhof); Tr. Vol. 11 at 1783:15-1786:3 (Chasen).

Congress' grossly misleading and inaccurate language, comparing the procedure to the "killing of a newborn infant," appears to have been intentional. Congress was aware that the Act as written applied to previable fetuses. In fact, as noted in this court's discussion regarding the Act's undue burden, Congress rejected alternatives and amendments to the Act that would have limited its applicability to viable fetuses. *See* 149 Cong. Rec. S3600 (daily ed. March 12, 2003) (statement of Sen. Feinstein); 149 Cong. Rec. H4939

> The intact [D & E] procedure involves literally delivering the fetus so that only the head remains within the cervix. At this juncture, the fetus is merely inches from being delivered and obtaining the full legal rights of personhood under the U.S. Constitution. . . . [M]any otherwise prochoice individuals have found intact [D & E] too close to infanticide to ethically justify its continued use.

Exh. A-55, at 745. In support, that article cites to one Senator's statement that intact D & E "is as close to infanticide as anything I have come upon," as reported by *The Washington Post*. *Id.* at 746 & n. 20.

(daily ed. June 4, 2003) (statement of Rep. Greenwood); 149 Cong. Rec. H4948 (daily ed. June 4, 2003) (statement of Rep. Baldwin). Moreover, government witness, Dr. Cook, who testified twice before Congress, testified before this court that he suggested to Congress limiting the applicability of the law to 20 weeks lmp, and his advice was ignored. Tr. Vol. 9 at 1529:7-21 (Cook).

Finally, for reasons that this court has already discussed with respect to the undue burden and overbreadth of the law, a "live" fetus is not the same as a "viable" fetus. In using the term "live," Congress appears to have intentionally disregarded the relevant medical distinction.

vi. *Fetal Pain*

Congress also made findings that, in the course of an intact D & E, the fetus experiences pain.[60] *See* Act, § 2(14)(M). This finding appears to have been based on the testimony of a nurse from Dr. Haskell's office who claimed that she observed an intact D & E on a 26 week lmp fetus who visibly showed signs of pain,[61] and on the

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[60] Congress found that "the fetus' perception of pain is even more intense than that of newborn infants and older children when subjected to the same stimuli" and that the "fetus fully experiences the pain associated with decompression of the skull and suction of its contents." *See id.* at § 2(14)(M). This is commensurate with the Sprang/Neerhof article, which concluded that: "[W]ith intact [D & E], pain management is not provided for the fetus, which is literally within inches of being delivered. Forcibly incising the cranium with a scissors and then suctioning out the intracranial contents is certainly excruciatingly painful." Exh. A-55, at 745.

[61] Dr. Haskell's office rebutted the nurse's testimony with a letter to Congress attesting that he did not perform the procedure on fetuses post-24 wks. Additionally, the nurse's testimony to that

testimony and submissions of other physicians, including several articles on the subject authored by Dr. Anand, a government witness before this court.[62]

For the reasons discussed in this court's findings, there is debate within the medical community on this issue. Therefore, the position that Congress has taken is neither incorrect nor entirely unsupported. It is, however, irrelevant to the question of whether the Act requires a health exception, as discussed in this court's conclusions of law.

vii. *Impact on Medical Profession*

Finally, Congress also found that the Act preserves the integrity of the medical profession. *See* Act, § 2(14)(G). In support, Congress found that intact D & E "confuses the medical, legal, and ethical duties of physicians to preserve and promote life" because the "physician acts directly against the physical life of a child, whom he or she had just delivered, all but the head, out of the womb, in order to end that life." *Id.* at § 2(14)(J). Congress further asserts that the procedure "appropriates the terminology and techniques used by obstetricians in the delivery of living children ... and instead uses those techniques to end the life of the partially-born child." *Id.* Accordingly, Congress found that intact D & E "undermines the public's perception

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effect was ruled inadmissible in subsequent litigation. *See* Record Exh. F, at 17-21, 205-206.

[62] All of those articles were published considerably prior to any of the *Stenberg* decisions. *See, e.g.*, Record Exh. A, at 4 & n. 6 (citing Anand & Hickey, *Pain and Its Effects in the Human Neonate and Fetus*, 317 New England Journal of Medicine 1321 (Nov. 1987) in support of the proposition that "[i]t is well documented that a baby is highly sensitive to pain stimuli at [around 20 weeks] and even earlier").

of the appropriate role of a physician during the delivery process, and perverts a process during which life is brought into the world, in order to destroy a partially-born child." *Id.* at § 2(14)(K).

Aside from Congress' mischaracterization of the intact D & E procedure, which is already discussed above and in this court's findings, Congress' conclusion that the Act would somehow promote the integrity of the medical profession is not supported by the evidence before Congress or before this court. In addition to the plaintiffs' witnesses who all discussed the extraordinarily negative impact that the Act would have and has had on their relationships with their patients and on their ability to provide the care that they deem to be in their patients' best interests, many, if not all, of the government witnesses also testified contrary to this congressional finding.

Dr. Cook, who testified before Congress, testified at trial that if he had written the bill, he probably would have written it so that physicians had greater leeway depending on whether fetal demise had already occurred. Tr. Vol. 9 at 1524:10-1526:8 (Cook). Moreover, Dr. Shadigian agreed, testifying that "the decision of whether there is a threat to the woman's life must be left to the physician's best medical judgment." Tr. Vol. 8 at 1322:1-4 (Shadigian); *see also* Tr. Vol. 6 at 944:15-19 (Bowes) (agreeing that regarding a medical exception, "a physician should be permitted to rely on his or her own best medical judgment to determine if there is such an emergency").

Further, as noted above, many major medical organizations, including ACOG, AMWA, and the CMA oppose the Act on this basis alone. The CMA submitted an amicus brief before this court that was especially

illustrative of the negative impact that the ban will have on the medical profession. The CMA was persuasive in noting that the Act will likely have the following adverse consequences:

> (1) it will disrupt the informed consent relationship between physicians and their patients because physicians are ethically bound to assist the patient in choosing among safe medical options and providing the safest care possible consistent with the patients' wishes;
>
> (2) because of the ambiguity in the act, it will have a particularly chilling effect on all abortion practices since physicians will have difficulty interpreting what conduct is prohibited by the Act;
>
> (3) the Act's lack of a health exception will prevent physicians from exercising their best medical judgment in light of a woman's particular condition and situation;
>
> (4) the Act could have the effect of placing physicians in an awkward situation with their staff, and could result in a conflict of interest very similar to the nurse who testified before Congress;
>
> (5) the Act's civil liability provisions may force physicians to violate patients' confidentiality, requiring the consent of the patients' husband or parents under certain circumstances; and
>
> (6) the Act could hinder medical advancements in reproductive health.

See generally March 25, 2004 CMA amicus brief.

d. Conclusion Regarding Deference to Congress' Finding that a Health Exception is Unnecessary

It is apparent to this court, upon examination of the record before Congress and the evidence presented at trial, that Congress' ultimate finding that "partial-birth abortion" is never necessary to preserve the health of the mother is the type of "finding" described by Justice Thomas in *Lamprecht v. FCC*.[63] In that case, Justice Thomas noted:

> We know of no support . . . for the proposition that if the constitutionality of a statute depends in part on the existence of certain facts, a court may not review a legislature's judgment that the facts exist. If a legislature could make a statute constitutional simply by "finding" that black is white or freedom, slavery, judicial review would be an elaborate farce. At least since *Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 2 L. Ed. 60 (1803), that has not been the law.

958 F.2d 382, 392 n. 2 (D.C. Cir. 1992).

For all of the reasons discussed above, this court concludes that Congress' "finding" that the intact D & E procedure is never medically necessary is unreasonable and is not supported by substantial evidence as was available to Congress at the time. Accordingly, this court declines to defer to Congress' "finding." *See Turner II*, 520 U.S. at 196, 117 S. Ct. 1174.

Instead, this court will rely on its own findings set forth above, based on the evidence before this court,

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[63] In *Lamprecht*, the D.C. Circuit held that an FCC preference for female owners of radio stations violated equal protection principles. 958 F.2d 382 (D.C. Cir. 1992).

deferring also to the Supreme Court's decision in *Stenberg* because:

> When the Court has interpreted the Constitution, it has acted within the province of the Judicial Branch, which embraces the duty to say what the law is. When the political branches of the Government act against the background of judicial interpretation of the Constitution already issued, it must be understood that in later cases and controversies the Court will treat its precedents with the respect due them under settled principles, including *stare decisis*, and contrary expectations must be disappointed.

City of Boerne, 521 U.S. at 534, 117 S. Ct. 2157 (citations omitted) (striking down the RFRA and concluding that it "is the Court's precedent, not RFRA, which must control").

E. Conclusions of Law: A Health Exception is Constitutionally Required

Based on the evidence before this court, and the court's determination that Congress' ultimate finding that partial-birth abortion is never necessary to preserve the health of the mother is not entitled to deference, the court finds that the Act's life exception is constitutionally inadequate.

As noted, the Supreme Court was clear in *Stenberg* that a health exception is required "[w]here substantial medical authority supports the proposition that banning a particular abortion procedure could endanger women's health." 530 U.S. at 938, 120 S. Ct. 2597. Under those circumstances, the *Stenberg* Court held that "*Casey* requires the statute to include a health exception when the procedure is 'necessary, in

appropriate medical judgment, for the preservation of the life *or health* of the mother.'" *Id.*

Here, the evidence establishes that the Act would ban procedures performed prior to 24 weeks lmp, which is generally considered previability. However, based on the Supreme Court's holding in *Stenberg*, the necessity of a health exception does not depend on whether the 24 week period is considered pre- or postviability. *Id.* at 931, 120 S. Ct. 2597. Accordingly, to the extent that there is any dispute regarding fetal viability in accordance with the evidence before this court, the court's conclusion that a health exception is required does not depend on whether the procedures at issue are performed pre- or postviability.

The Act here excepts only "a partial-birth abortion that is necessary to save the life of a mother." The court finds, however, that a health exception is necessary as well because, the three "medically related evidentiary circumstances" present before the Supreme Court in *Stenberg* exist here as well. *See id.* at 936-37, 120 S. Ct. 2597.

First, the record before this court, like the district court's record in *Stenberg*, demonstrates that "significant medical authority supports the proposition that in some circumstances, [intact D & E] is the safest procedure." *Id.* at 932, 120 S. Ct. 2597. These include the following considerations, present also in the *Stenberg* case, that among other maternal and fetal conditions for some woman, other abortion procedures present "a larger than necessary risk" of:

> (1) a longer operating time; (2) greater blood loss and infection; (3) complications from bony fragments; (4) instrument-inflicted damage to the uterus

> and cervix; (5) exposure to the most common causes of maternal mortality (DIC and amniotic fluid embolus); [and] (6) complications arising from retained fetal parts.

Carhart II, 11 F.Supp.2d at 1127.

While this court has also found that an intact D & E, under these circumstances, may not be the *only* safe option available to preserve the life or the health of a woman, that finding does not undermine the necessity of a health exception in this case. As the Supreme Court explained in *Stenberg*, such a finding is irrelevant where the evidence demonstrates that intact D & E is "significantly safer." *Stenberg*, 530 U.S. at 934, 120 S. Ct. 2597. This court has similarly found that intact D & E may be significantly safer for certain women under the particular circumstances listed above.[64]

Second, for the reasons explained above, this court has also found that there continues to be a division of opinion among highly qualified experts regarding the necessity or safety of intact D & E. If anything, since the Supreme Court's decision in *Stenberg*, the evidence before this court suggests that the majority of highly-qualified experts on the subject believe intact D & E to be the safest, most appropriate procedure under certain circumstances.

Finally, as discussed, there continues to be an absence of controlled medical studies that provide a definitive answer regarding the safety and necessity of intact D & E. However, those studies that have been

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[64] Moreover, to the extent that the Act bans D & E by disarticulation, which this court has found that it does (in accordance with the undue burden analysis), a health exception is undoubtedly necessary, and the Act is unconstitutional on that basis alone.

conducted since the Supreme Court decided *Stenberg*, including the Chasen study, provide medical support for the conclusion that intact D & E is a safe, and sometimes necessary, procedure. While the government has suggested a lack of diligence or effort on the part of the Act's opponents in conducting such controlled medical studies, as this court has noted, experts agree that the Chasen study is the "first step" in conducting even more comprehensive studies regarding intact D & E.[65]

The government's interests in protecting potential life and minimizing potential pain to the fetus do not alter this court's finding regarding the necessity of a health exception. In *Stenberg*, the Supreme Court rejected the same arguments that were made by Nebraska regarding the state's interests in that case. 530 U.S. at 930-931, 120 S. Ct. 2597. The Court recognized that "subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion. . . ." *Id.* at 931, 120 S. Ct. 2597. Nevertheless, it found Nebraska's argument regarding its interest in the potentiality of life unpersuasive because, like the Act here, Nebraska's law did not "sav[e] the fetus from destruction," but instead simply "regulate[d] only a *method* of performing abortion." *Id.* Most significantly, the Supreme Court held that Nebraska's alleged interests did not "make any difference to the question at hand, namely, the application of the 'health' requirement." *Id.*

Accordingly, for these reasons, this court does not find that the government's asserted fetal interests

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[65] The court notes that enforcement of the Act would make any further studies impossible to conduct.

override the necessity of a health exception to preserve the life and health of the mother.

Nor does this court find that the possibility of inducing fetal demise prior to performing an intact D & E obviates the need for a health exception. The government has suggested that physicians and patients can avoid falling within the Act's prohibitions if fetal demise, by chemical injection or otherwise, is induced prior to the procedure. However, to read into the Act such a requirement would, for the reasons discussed in this court's findings, subject women to unnecessary side effects and risks, however small, without providing any medical benefit to them. Moreover, there are certain circumstances under which inducing fetal demise is not possible or effective.

Accordingly, for all the reasons discussed above, this court finds that the Act's omission of a health exception renders the Act unconstitutional.[66]

CONCLUSION

For all of the reasons discussed above, this court concludes that the Act is unconstitutional because it (1) poses an undue burden on a woman's ability to choose a second trimester abortion; (2) is unconstitutionally vague; and (3) requires a health exception as set forth by the Supreme Court in *Stenberg*. Permanent injunctive relief is appropriate given that plaintiffs have demonstrated that the Act violates their constitutional rights on the above three bases. *See Elrod v. Burns*, 427 U.S. 347, 373, 96 S. Ct. 2673, 49 L. Ed. 2d 547 (1976);

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[66] In view of this finding, it is unnecessary for the court to reach the plaintiffs' challenge to the adequacy of the existing life exception on the basis that it does not provide for a determination made pursuant to the physician's "appropriate medical judgment."

see also Monterey Mech. Co. v. Wilson, 125 F.3d 702, 715 (9th Cir.1997).

Accordingly, defendant John Ashcroft, in his official capacity as Attorney General of the United States, and his employees, officers, agents, attorneys, and successors in office are PERMANENTLY ENJOINED from enforcing the Partial-Birth Abortion Ban Act of 2003 against plaintiffs Planned Parenthood Federation of America and Planned Parenthood Golden Gate, intervenors City and County of San Francisco, their members, officers, agents, servants, employees, contractors, and those persons in active concert or participation with those persons listed above. This order applies to those persons set forth above as they render services in any facility, including facilities that are not owned or operated by plaintiffs and/or intervenors.[67]

The clerk shall close the file.

IT IS SO ORDERED.

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[67] While recognizing that a nationwide injunction may be appropriate, in deference to the New York and Nebraska courts, this court declines plaintiffs' request to issue a nationwide injunction at this time. *See Bresgal v. Brock*, 843 F.2d 1163, 1170-71 (9th Cir. 1987) (nationwide injunction not necessarily overbroad where "such breadth is necessary to give prevailing parties the relief to which they are entitled").

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No. 05-1382

In the Supreme Court of the United States

ALBERTO R. GONZALES, ATTORNEY GENERAL,
PETITIONER

v.

PLANNED PARENTHOOD FEDERATION
OF AMERICA, INC., ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

REPLY BRIEF FOR THE PETITIONER

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REPLY BRIEF FOR THE PETITIONER

Respondents contend that, rather than holding the petition for a writ of certiorari pending its decision in *Gonzales* v. *Carhart*, No. 05-380, the Court should grant certiorari in this case and consolidate it with *Carhart*. Respondents, however, offer no compelling reason that the Court should take that duplicative approach. The merits briefing in *Carhart* is already well underway, and *Carhart* provides an appropriate vehicle to address the principal constitutional challenges that have been launched against the Partial-Birth Abortion Ban Act of 2003, including the overbreadth and vagueness arguments on which respondents focus. The petition for certiorari should therefore be held until this Court's decision in *Carhart*, and then disposed of accordingly.

1. Respondents primarily contend (Planned Parenthood Br. 8-9; San Francisco Br. 8-10) that certiorari is necessary in this case because, in *Carhart*, the court of

appeals did not address arguments that the Act was facially invalid because it was unconstitutionally overbroad and vague. Respondents do not deny, however, that this Court *could* address those arguments in *Carhart*, in light of the fact that the plaintiffs in *Carhart* preserved those arguments in the lower courts.[1] In its supplemental brief in support of certiorari in *Carhart* (at 8-9 & n.2), the government explained why it would be appropriate for the Court to address those arguments, even though the court of appeals had not passed on them. The Court granted certiorari in *Carhart* without narrowing or reframing the government's question presented, which asked the Court to consider whether the Act is invalid "because it lacks a health exception *or is otherwise unconstitutional on its face*." *Carhart* Pet. at i (emphasis added).[2] In its opening merits brief in *Carhart*, the government has addressed the overbreadth

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[1] Respondents correctly note (Planned Parenthood Br. 8-9; San Francisco Br. 8-9) that the plaintiffs in *Carhart* did not expressly argue before the court of appeals that the Act was unconstitutionally vague. Respondents do not deny, however, that the plaintiffs advanced a vagueness argument before the district court, and they appear to acknowledge that the vagueness argument overlaps, at least to some extent, with the overbreadth argument, which the *Carhart* plaintiffs unquestionably *did* advance before the court of appeals. See Planned Parenthood Br. 9; San Francisco Br. 9. While those arguments are conceptually distinct, that overlap is substantial, insofar as both arguments turn on the construction of the same statutory language. Cf. *Carhart* Pet. Br. at 44-48 (discussing overbreadth and vagueness arguments). Nor do respondents contend that their overbreadth or vagueness claims in any way differ from those advanced by the plaintiffs in *Carhart*.

[2] Contrary to the suggestion of respondent Planned Parenthood (Br. 11 n.8), the italicized language makes clear that the question presented by the government's petition in *Carhart* expressly encompasses *all* facial challenges that have been launched against the Act.

and vagueness issues. See *Carhart* Pet. Br. at 44-48. Because there is no obstacle to the Court's considering and deciding those issues in *Carhart*, if it so chooses, there is no reason for the Court to grant plenary review in this case as well, and thus precipitate an additional round of merits briefing and, presumably, amicus filings on issues that will already be exhaustively addressed in the briefs in *Carhart* itself.[3]

2. Respondents suggest (Planned Parenthood Br. 7, 9-10; San Francisco Br. 8-9) that this case would constitute a better vehicle than *Carhart* for consideration of the overbreadth and vagueness claims because the district court made more detailed factual findings on, and the lower courts engaged in more substantial analysis of, those claims. There is no reason, however, that the Court cannot consider the findings and analysis of the lower courts in this case, to the extent they are relevant, in the context of analyzing the overbreadth and vagueness claims in *Carhart*. Indeed, in its opening merits brief in *Carhart*, the government not only discusses the factual findings made by the district court in this case, see *Carhart* Pet. Br. at 40, but also discusses (or cites) the analysis of the court of appeals on the overbreadth and vagueness claims, see *id.* at 47 n.14, 49. Moreover, substantial portions of the record in this case were in-

[3] Respondent San Francisco also notes (Br. 9) that the court of appeals in *Carhart* did not address the issue whether, assuming that the Act is unconstitutional, narrower injunctive relief would be appropriate under this Court's intervening decision in *Ayotte* v. *Planned Parenthood of Northern New England*, 126 S. Ct. 961 (2006). The Court, however, need not address the remedial issue in *Carhart* if it finds that the Act is constitutional. In any event, it unquestionably could address that remedial issue if it so chooses—or leave that issue to be decided on remand once the Court definitively passes on the Act's constitutionality.

corporated into the record before the district court in *Carhart*, and therefore may directly be considered by the Court in that case. See, *e.g.*, *Carhart* J.A. at 510-563, 622-706, 823-869.

3. Respondents also contend (Planned Parenthood Br. 10-11; San Francisco Br. 8) that the overbreadth and vagueness arguments are "threshold" arguments that the Court should consider first before addressing whether the Act is facially invalid because it lacks a health exception. That is not how the court of appeals approached the analysis in this case; it addressed the health-exception issue *before* the overbreadth and vagueness issues. Compare Pet. App. 14a-22a (health exception) with *id.* at 23a-40a (overbreadth and vagueness). In any event, the critical point is that the *primary* ground on which the Act was challenged in the lower courts—in this case, in *Carhart*, and in litigation in the Second Circuit, see *National Abortion Fed'n* v. *Ashcroft*, 437 F.3d 278 (2006)—was that the Act lacked a health exception. And even assuming, *arguendo*, that the overbreadth and vagueness arguments were "threshold" arguments that should be addressed first, that point would provide no additional justification for granting plenary review in this case, since, as explained, there is no reason that the Court could not address those arguments in that sequence in *Carhart* itself, if it chooses to do so.

4. Finally, granting certiorari in this case would precipitate another round of essentially duplicative briefing. Since the petition for a writ of certiorari was filed in this case, the government has filed its opening merits brief in *Carhart*, and numerous amicus briefs have been filed in support of the government. Absent an extension of time, respondents' merits brief, along with

any amicus briefs supporting respondents, would be due on June 26, 2006, and the government's reply brief would be due on July 31, 2006. The case will therefore be fully briefed and ready for oral argument in the Court's October sitting. Assuming that this case would be consolidated with *Carhart* for purposes of oral argument, granting certiorari in this case could delay the ultimate resolution of the extraordinarily important question of the Act's constitutionality. Given that *Carhart* presents an opportunity to address all the principal challenges to the Act, there is no reason for the Court to invite such additional briefing and possible delay by granting plenary review in this case as well.[4]

* * * * *

For the foregoing reasons and those stated in the petition, the petition for a writ of certiorari should be held pending this Court's disposition of *Gonzales* v. *Carhart*, No. 05-380, and then disposed of accordingly.

Respectfully submitted.

PAUL D. CLEMENT
Solicitor General

MAY 2006

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[4] Of course, respondents may file amicus briefs in *Carhart* and discuss, *inter alia*, any unique perspectives that they claim the court of appeals' decision in this case may provide with respect to the constitutionality of the Act.

Supreme Court, U.S.
FILED
AUG 3 - 2006
OFFICE OF THE CLERK

No. 05-1382

In the Supreme Court of the United States

ALBERTO R. GONZALES, ATTORNEY GENERAL,
PETITIONER

v.

PLANNED PARENTHOOD FEDERATION OF AMERICA,
INC., ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

JOINT APPENDIX
(VOLUME 1)

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PETITION FOR A WRIT OF CERTIORARI FILED: MAY 1, 2006
CERTIORARI GRANTED: JUNE 19, 2006

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UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 04-16621

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., ET AL., PLAINTIFF-APPELLEES

v.

ALBERTO R. GONZALES, ATTORNEY GENERAL OF THE UNITED STATES, IN HIS OFFICIAL CAPACITY, DEFENDANT-APPELLANT

DOCKET ENTRIES

DATE	PROCEEDINGS
8/20/04	DOCKETED CAUSE AND ENTERED APPEARANCES OF COUNSEL. CADS SENT (Y/N): no. setting schedule as follows: appellant's designation of RT is due 8/12/04; appellee's designation of RT is due 8/23/04,,; appellant shall order transcript by 9/1/04; court reporter shall file transcript in DC by 10/4/04,,; certificate of record shall be filed by 10/12/04; appellant's opening brief is due 11/18/04; appellees' brief is due 12/20/04,,; appellants' reply brief is due 1/3/05; [04-16621] (dg)

* * * * *

DATE	PROCEEDINGS
12/21/04	Filed original and 15 copies aplt's opening brf (Informal: no) of 64 pages and five excerpts of record in 7 volumes; served on 12/20/04. [04-16621] (jr)
	* * * * *
2/18/05	Filed original and 15 copies aple's (City and County of S.F.) brf of 33 pages and 5 copies excerpts of record in 1 vol; served on 2/18/05. Minor defcy; excerpts need white covers. Notified counsel. [04-16621] (jr)
	* * * * *
3/2/05	Filed original and 15 copies aples' (Planned Parenthood) 80 page brf and 5 copies suppl excerpts of record in 3 vols; served on 2/18/05. [04-16621] (jr)
	* * * * *
4/7/05	Filed original and 15 copies John Ashcroft reply brief, (Informal: no) 35 pages and 1 vol SER; served on 3/30/05 [04-16621] (crw)
	* * * * *
10/20/05	ARGUED AND SUBMITTED TO Stephen R. REINHARDT, Sidney R. THOMAS, William A. FLETCHER [04-16621] (gva)
	* * * * *

DATE	PROCEEDINGS
1/31/06	FILED OPINION: AFFIRMED (Terminated on the Merits after Oral Hearing; Affirmed; Written, Signed, Published. Stephen R. REINHARDT, author; Sidney R. THOMAS; William A. FLETCHER.) FILED AND ENTERED JUDGMENT. [04-16621] (crw)
	* * * * *
3/27/06	MANDATE ISSUED [04-16621] (gar)

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. 03-CV-04872

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.,

v.

JOHN ASHCROFT

DOCKET ENTRIES

DATE	DOCKET NUMBER	PROCEEDINGS
10/31/2003	1	COMPLAINT against John Ashcroft (Filing fee $150.00 receipt number 3353053). Filed by Planned Parenthood Federation of America, Inc., Planned Parenthood Golden Gate. (gba, COURT STAFF) Additional attachment(s) added on 11/4/2003 (gba, COURT STAFF). Additional attachment(s) added on 11/4/2003 (gba, COURT STAFF). (Entered: 10/31/2003)
		* * * * *
11/03/2003	7	Ex Parte MOTION for Temporary Restraining Order Plaintiffs' Notice of Ex Parte

DATE	DOCKET NUMBER	PROCEEDINGS
		Motion and Motion for a Temporary Restraining Order and An Order to Show Cause Regarding Preliminary Injunction filed by Planned Parenthood Federation of America, Inc., Planned Parenthood Golden Gate. Motion Hearing set for 11/5/2003 09:00 AM. (Attachments: # 1 Proposed Order for Temporary Restraining Order and Order to Show Cause Regarding Preliminary Injunction) (Parker, Beth) (Entered: 11/03/2003)
		* * * * *
11/05/2003	21	Memorandum in Opposition re 7 Plaintiffs' Motion for a Temporary Restraining Order filed by John Ashcroft. (Quinlivan, Mark) (Entered: 11/05/2003)
		* * * * *
11/06/2003	29	Minute Entry: Plaintiffs' Motion for a Temporary Restraining Order held on 11/6/2003 before Phyllis J. Hamilton—GRANTED as stated on the Record. A

DATE	DOCKET NUMBER	PROCEEDINGS
		written order will issue tomorrow. (Court Reporter Leo Mankiewicz.) (lm, COURT STAFF) (Entered: 11/06/2003)
		* * * * *
11/07/2003	31	ORDER (Granting Plaintiffs' Motion for Temporary Restraining Order): Signed by Judge Phyllis J. Hamilton on 11/7/03. (lm, COURT STAFF) (Entered: 11/07/2003)
		* * * * *
11/13/2003	33	Supplemental AMENDED COMPLAINT against John Ashcroft. Filed by Planned Parenthood Federation of America, Inc., Planned Parenthood Golden Gate. (Attachments: # 1 Exhibit A—The Act) (Parker, Beth) (Entered: 11/13/2003)
		* * * * *
11/25/2003	42	MOTION to Intervene Points and Authorities in Support; Complaint in Intervention filed by City and County of San Francisco. Motion Hearing set for 1/7/2004 09:00 AM. (Attach

DATE	DOCKET NUMBER	PROCEEDINGS
		ments: # 1 Complaint in Intervention # 2 Proposed Order # 3 Affidavit Declaration of Mitchell Katz in Support of Motion of the City and County of San Francisco to Intervene as Plaintiff # 4 Affidavit Attestation by Therese Stewart to the Declaration of Mitchell Katz) (Stewart, Therese) (Filed on 11/25/2003) (Entered: 11/25/2003)
		* * * * *
01/08/2004	54	ORDER: granting 42 Motion to Intervene—City & County of San Francisco. The pretrial schedule already entered shall apply equally to CCSF by Judge Phyllis J. Hamilton. (lm, COURT STAFF) (Filed on 1/8/2004) (Entered: 01/08/2004)
		* * * * *
03/29/2004	208	Minute Entry: Bench Trial began on 3/29/2004 before Phyllis J. Hamilton for 3 weeks. Matter continued to 3/30/04 at 8:30 AM (Court Reporter: Diane Skillman) (lm, COURT

DATE	DOCKET NUMBER	PROCEEDINGS
		STAFF) (Date Filed: 3/29/2004) (Entered: 03/29/2004)
03/30/2004	209	TRIAL MINUTES: Continued Bench Trial held on 3/30/2004 before Phyllis J. Hamilton; continued to 4/1/04 at 8:30 AM for Further Court Trial. (Court Reporter Diane Skillman.) (lm, COURT STAFF) (Date Filed: 3/30/2004) (Entered: 03/30/2004)
		* * * * *
04/01/2004	212	TRIAL MINUTES: Continued Court Trial before Judge Phyllis J. Hamilton on 4/1/04. Matter was continued to 4/5/04 at 8:30 AM for Further Court Trial. (Court Reporter: Diane Skillman) (lm, COURT STAFF) (Filed on 4/1/2004) (Entered: 04/01/2004)
04/05/2004	213	TRIAL MINUTES: Continued Court Trial held on 4/5/2004 before Phyllis J. Hamilton. Matter continued to 4/6/04 at 8:30 AM (Court Reporter: Diane Skillman) (lm, COURT STAFF) (Date Filed: 4/5/2004) (Entered: 04/05/2004)

DATE	DOCKET NUMBER	PROCEEDINGS
		* * * * *
04/06/2004	217	TRIAL MINUTES: Continued Trial held on 4/6/2004 before Phyllis J. Hamilton. Matter continued to 4/8/04 at 8:30 AM for Further Court Trial. (Court Reporter: Diane Skillman) (lm, COURT STAFF) (Date Filed: 4/6/2004) (Entered: 04/06/2004)
		* * * * *
04/08/2004	221	TRIAL MINUTES: Continued Court Trial held on 4/8/2004 before Phyllis J. Hamilton. Matter was continued to 4/9/04 at 8:30 A.M. for Further Court Trial (Court Reporter Diane Skillman.) (lm, COURT STAFF) (Date Filed: 4/8/2004) (Entered: 04/08/2004)
04/09/2004	222	Minute Entry: Continued Court Trial held on 4/9/2004 before Phyllis J. Hamilton. Matter continued to 4/12/04 at 8:30 A.M. for Further Court Trial. (Court Reporter: Diane Skillman.) (lm, COURT STAFF) (Date Filed: 4/9/2004) (Entered: 04/09/2004)

DATE	DOCKET NUMBER	PROCEEDINGS
04/12/2004	223	Minute Entry: Continued Court Trial held on 4/12/2004 before Phyllis J. Hamilton. Matter continued to 4/13/04 at 8:30 AM for Further Court Trial. (Court Reporter: Diane Skillman.) (lm, COURT STAFF) (Date Filed: 4/12/2004) (Entered: 04/12/2004)
04/13/2004	224	TRIAL MINUTES: Continued Bench Trial held on 4/13/2004 before Phyllis J. Hamilton. 4/26/04—Supplemental Findings. Matter was continued to 4/15/04 at 8:30 AM for Further Court Trial. (Court Reporter: Diane Skillman) (lm, COURT STAFF) (Date Filed: 4/13/2004) (Entered: 04/13/2004)
		* * * * *
04/15/2004	227	TRIAL MINUTES: Continued Court Trial held on 4/15/2004 before Phyllis J. Hamilton. Matter continued to 4/16/04 at 8:30 AM for Further Court Trial. (Court Reporter: Diane Skillman.) (lm, COURT STAFF) (Date Filed: 4/15/2004) (Entered 04/15/2004)

DATE	DOCKET NUMBER	PROCEEDINGS
04/16/2004	228	TRIAL MINUTES: Bench Trial completed on 4/16/2004 before Phyllis J. Hamilton. (Court Reporter: Diane Skillman) (lm, COURT STAFF) (Date Filed: 4/16/2004) (Entered: 04/16/2004)
		* * * * *
04/23/2004	231	Proposed Findings of Fact by City and County of San Francisco City and County of San Francisco's Supplemental Findings of Fact and Conclusions of Law. (Van Runkle, Aleeta) (Filed on 4/23/2004) (Entered: 04/23/2004)
		* * * * *
04/26/2004	234	Proposed Findings of Fact by Planned Parenthood Federation of America, Inc., Planned Parenthood Golden Gate Supplemental Proposed Findings of Fact and Conclusions of Law. (Parker, Beth) (Filed on 4/26/2004) (Entered: 04/26/2004)

DATE	DOCKET NUMBER	PROCEEDINGS
04/26/2004	235	Proposed Findings of Fact by John Ashcroft Defendant's Post-Trial Proposed Findings of Fact and Conclusions of Law. (Simpson, W.) (Filed on 4/26/2004) (Entered: 04/26/2004)
06/01/2004	236	ORDER GRANTING PERMANENT INJUNCTION; FINDINGS OF FACT AND CONCLUSIONS OF LAW IN SUPPORT THEREOF. Signed by Judge Hamilton on June 1, 2004. (pjhlc3,) (Filed on 6/1/2004) (Entered: 06/01/2004)
		* * * * *
08/02/2004	243	NOTICE OF APPEAL by John Ashcroft. Appeal Record due by 9/1/2004. (Attachments: # 1) (Simpson, W.) (Filed on 8/2/2004) (Entered: 08/02/2004)
		* * * * *

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C 03-4872 PJH

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. AND PLANNED PARENTHOOD GOLDEN GATE, PLAINTIFFS

v.

JOHN ASHCROFT, ATTORNEY GENERAL OF THE UNITED STATES, IN HIS OFFICIAL CAPACITY, DEFENDANT

TRANSCRIPT OF PROCEEDINGS
Monday, Mar. 29, 2004
Volume 1

BEFORE THE HONORABLE
PHYLLIS J. HAMILTON, JUDGE

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* * * * *

[MAUREEN PAUL, M.D.—DIRECT EXAMINATION]

[6]

* * * * *

Q. Dr. Paul, are you board certified in any area?

A. Yes, in obstetrics and gynecology and also occupational and environmental medicine.

Q. And are you the chief medical officer at Planned Parenthood Golden Gate?

A. Yes, I am.

Q. What does that position entail?

A. The actual overseeing the quality of medical care at Planned Parenthood Golden Gate; providing direct clinical services, participating in strategic planning for the organization; hiring of the physicians to work at Golden Gate; and also supervising both the physicians and the advanced practice clinicians who work at Planned Parenthood Golden Gate, [7] as well as developing clinical protocols that we use in the clinics.

Q. At how many sites does Planned Parenthood Golden Gate provide medical services?

A. Eight.

Q. And where are those sites located, generally?

A. Throughout the San Francisco Bay area.

Q. And what medical services are available at Planned Parenthood Golden Gate?

A. Planned Parenthood Golden Gate provides primary health care services, in that we do general physical exams and take care of common health conditions that people may have. We also provide a broad range of reproductive health care services, including contraception and abortion, basic gynecological exams, pap tests, treatment of abnormal pap tests, diagnosis of and management of sexually-transmitted infections and HIV testing and referral.

Q. And are abortions available at all eight of the Planned Parenthood Golden Gate sites?

A. Yes.

Q. And to what gestational age are abortions performed at Planned Parenthood Golden Gate?

A. Eighteen weeks, six days of pregnancy.

Q. And what methods of abortion are available at Planned Parenthood Golden Gate?

[8]

A. We provide early medical abortion, vacuum aspiration abortion, and dilation and evacuation or D&E abortion.

Q. And you said that you currently provide abortions to 18 weeks, six days; is that correct?

A. That's correct.

Q. Is it your plan to increase the gestational age at which abortions are available at Planned Parenthood Golden Gate?

A. Yes.

Q. Now, in addition to your work as the chief medical officer Planned Parenthood Golden Gate, are you also an associate clinical professor in the Department of Obstetrics Gynecology and Reproductive Sciences at University of California at San Francisco?

A. Yes, I am.

Q. And what does that involve?

A. That involves teaching, and we are also setting up a collaborative research program between UCSF and Planned Parenthood Golden Gate. The teaching primarily involves early abortion methods.

Q. And are you also the director of training at the UCSF Center for Reproductive Health Research and Policy?

A. Yes, I am.

Q. And what does that involve?

A. That is the position that I hold where I do the training in early abortion, primarily for primary care residency programs, [9] such as family practice residency programs where building and training consortium, academic community collaboration to provide training to the residents and faculty in the primary care residency programs.

Q. And Dr. Paul, do you have clinical experience performing first-trimester abortions using both surgical and medical methods?

A. Yes, I do.

Q. Is that a significant part of your medical practice?

A. Yes, it is.

Q. And do you have clinical experience performing D&E abortions?

A. Yes, I do.

Q. And is that a significant part of your medical practice?

A. Yes, it is.

Q. And in your current practice to what gestational age do you personally perform D&E abortions?

A. I perform D&E abortions to 18 weeks, six days gestation.

Q. And at other times in your career have you performed D&E's to later gestational ages?

A. Yes, I have. During residency I performed D&E's to about 23 weeks gestation.

Q. And do you have clinical experience performing induction abortions?

A. Yes, I do.

[10]

Q. Do you perform induction abortions in your current practice?

A. No, I don't.

Q. When did you perform inductions?

A. I performed inductions when I was a faculty member at Tufts New England Medical Center and at the University of Massachusetts Medical Center. It was a period of about 12 years.

Q. Have you ever conducted clinical research in the area of abortion?

A. Yes, I have.

Q. Have you ever designed or conducted a randomized trial?

A. Yes, I have.

Q. And did that involve abortion?

A. No, I conducted a randomized trial that compared methods of induction at term.

Q. And do you currently teach abortion methods?

A. I do.

Q. To whom do you currently teach abortion methods?

A. I teach abortion methods to the family practice residents that I referred to earlier. That is primarily early abortion methods. Also teach early medical abortion methods to the advanced practice clinicians who work at Golden Gate.

I sometimes teach second-trimester D&E methods to the physicians who work at Planned Parenthood Golden Gate.

[11]

I have a history of giving lectures in the medical schools in which I worked, and those involved abortions.

Q. And when you refer to teaching abortion methods to residents, are those residents of UCSF?

A. Yes, the residents—we do teach the residents at UCSF.

We also teach residents who are in other residency programs throughout the bay area. And they come over to Planned Parenthood Golden Gate to train in early surgical abortion methods.

Q. And, Dr. Paul, am I correct that you are the editor-in-chief of the recent text on abortion?

A. Yes.

Q. And what is that text?

A. It's called a Clinician's Guide to Medical and Surgical Abortion.

Q. And in addition to being the editor-in-chief of that text, did you author or co-author any of the chapters in that book?

A. Yes, I did.

Q. When was that—when was that book published?

A. 1999.

Q. Can you describe what your role was as editor-in-chief of that text?

A. Yes. As editor-in-chief I was responsible for overseeing the process of production of the book, and I was the primary contact with the publisher. I also was the primary person to [12] coordinate the work of the other editors.

I did work directly with some of the authors. I reviewed all of the chapters of the book, and exercised editorial authority over those chapters.

Q. And do you know what the reputation of this text is in the medical community?

A. I believe it's the standard reference text on abortion care.

Q. In addition to the Clinician's Guide text, do you have other publications in the area of abortion?

A. Yes. I have several publications in the peer review literature.

Q. Are those outlined on your curriculum vitae?

A. They are.

Q. Dr. Paul, in addition to being a board certified Ob/Gyn, you have a master's in public health with a concentration in epidemiology; is that correct?

A. Yes.

Q. What is epidemiology?

A. Epidemiology is the study of the distribution and determinants of health-related conditions in the popula-

tion. Simply put, it's applying research methods to determine who gets health-related conditions and why.

Q. And what role does epidemiology play in your work?

A. I apply epidemiologic methods when I do research. I also [13] have done peer reviews of articles, manuscripts that are submitted by authors to major medical journals. And one thing we have to do is determine whether the epidemiologic methods that are used are appropriate for the topic of the manuscripts.

Q. Have you ever taught epidemiology?

A. I helped to teach a reproductive epidemiology course at the BU School of Public Health.

Q. What is "BU"?

A. I'm sorry, Boston University.

Q. Dr. Paul, have you ever testified before as an expert witness in a case challenging a law that restricts abortion practice or restricts access to abortion?

A. No.

MS. GARTNER: Your honor, plaintiffs would move to qualify Dr. Maureen Paul as an expert in obstetrics and gynecology, all facets of abortion care, and epidemiology.

THE COURT: Any objection?

MR. QUINLIVAN: No objection.

THE COURT: Do you wish to voir dire the witness at this time?

MR. QUINLIVAN: Not at this time, your honor.

THE COURT: All right. She will be accepted as qualified.

MS. GARTNER: Thank you, your honor.

[14]

BY MS. GARTNER:

Q. Dr. Paul, I would like to ask you some background questions about pregnancy. What is the average length of a full term pregnancy?

A. Forty weeks.

Q. And how is the gestational age of the fetus calculated?

A. In two ways. The gestational age can be calculated from the first day of the last menstrual period, which is sometimes referred to as LMP. Or an ultrasound can be used, also, to date the pregnancy.

Q. If ultrasound is used to date the pregnancy, do you still refer to the gestational age in terms of LMP?

A. It is common, no matter which way you date the pregnancy, to say, for instance, that a woman is eight weeks LMP.

Q. Can you tell me when the first-trimester of pregnancy ends?

A. The total duration of pregnancy is 40 weeks, and pregnancy is divided into three trimesters of equal duration. So the first-trimester ends at about 13 or 14 weeks.

Q. And when does the second-trimester end?

A. About 27 weeks.

Q. Dr. Paul, what do you under the word "viability" to mean?

A. I understand the word "viability" to mean that the fetus has a realistic chance of long-term survival outside the uterus.

Q. And based on the available data, can you tell me when, in [15] your opinion, a normally-developed fetus is likely to become viable?

A. About 24 weeks.

Q. And is that LMP?

A. Yes.

Q. And throughout your testimony, when you refer to the number of weeks, are you referring to that number of weeks LMP?

A. Yes.

THE COURT: Could I ask a question? Is LMP the first day or last day of the menstrual period?

THE WITNESS: The first day of the last menstrual period, your honor.

BY MS. GARTNER:

Q. Dr. Paul, does pregnancy ever cause serious medical conditions for the pregnant woman?

A. Yes.

Q. Can you give me some examples of those?

A. Yes. There are conditions that are specific to pregnancy. One example is a condition called "preeclampsia," which is a condition that affects many of the systems of the body. It presents as high-blood pressure, and protein in the urine. But it can also include abnormalities of the liver, abnormalities of the blood-clotting system.

And it can progress to seizures, in which case the condition is called "eclampsia." There are infections that are [16] specific to pregnancy like chorioamnionitis, which is an infection of the uterus that occurs only during pregnancy.

And then there are conditions that can happen in nonpregnant women, but are more likely to happen in pregnant women. And an example of that would be the propensity to have blood clots, either in the lower extremities or in the lungs.

And that is called thromboembolism and pulmonary embolus.

Q. These conditions, these examples you have given of preeclampsia, chorioamnionitis and the blood clots, when in pregnancy are these conditions likely to occur?

A. Preeclampsia and chorioamnionitis are more likely to occur in the second and third-trimester. Blood clots can occur any time.

Q. And what about in women that are already unhealthy in some respect, can pregnancy ever make their underlying medical conditions worse?

A. Absolutely.

Q. Can you give me some examples of that?

A. Yes. Pregnancy entails many changes that happen in the body that can be tolerated by normal women, who are normal and healthy, but can be very taxing to women who have underlying medical conditions.

An example might be heart conditions. For instance, the blood volume in pregnancy nearly doubles. The heart rate goes up.

[17]

Q. Let me just stop you there. You are talking about the blood volume of the pregnant woman?

A. The blood volume of the pregnant woman, that's right. The amount of blood in the system nearly doubles during pregnancy, and the heart rate goes up. The amount of blood that is coming through the heart and that has to go out to feed the tissues is therefore greater. And the heart is working harder. So that if you have a woman who has a heart condition, this can be very taxing.

It can cause increased pressures in the heart that can backup into the lungs and you can get things called "pulmonary edema," that is fluid in the lungs or heart failure.

Another example would be diabetes. There are hormonal changes that happen in pregnancy that can make it very difficult to control the blood sugars in a diabetic so that you can get dangerously low blood sugars leading to seizures, or you can get dangerously high blood sugars, which can result in coma. So those are a couple of examples.

Q. Is there a particular time in pregnancy when such underlying medical conditions tend to worsen?

A. They tend to worsen as pregnancy progresses.

Q. And, Dr. Paul, have you treated patients in your medical practice with all of the types of conditions that we've just discussed who have chosen to end their pregnancies because of those conditions?

[18]

A. Yes, and others.

Q. Have you treated patients who have chosen to end their pregnancy because the fetus is diagnosed as having a serious anomaly?

A. Yes.

Q. Can you give me some examples of those from your medical practice?

A. Basically two types: one is chromosomal anomalies.

Q. Why don't you tell us what is a chromosomal anomaly?

A. The chromosomes are basically packages of genetic material, so it is genetic types of defects. You can have too many chromosomes, too few chromosomes or chromosomes that have structural defects. And I have treated women who have had all of those types of chromosomal anomalies.

The other thing is just anomalies of the fetus that are structural anomalies so that they are visible birth defects.

Q. Can you give me one or two examples of those?

A. Heart defects, or there is a neural tube defects that are defects of the spinal cord or brain.

Q. Have you treated patients with those sorts of fetal anomalies that have chosen to end their pregnancies?

A. Yes.

Q. And at what gestational ages are abortions for fetal anomalies generally performed?

[19]

A. Generally after the first-trimester.

Q. And why is that?

A. Because we often can't diagnose these anomalies until after the first-trimester. There may be abnormalities that appear on an ultrasound that just don't appear until the second or third-trimester, and that is when we first attack the anomaly.

And there is also genetic tests that can only be done in second-trimester.

Q. Dr. Paul, can you just describe briefly what is "ultrasound"?

A. "Ultrasound" is using sound waves in order to visualize the pregnancy.

Q. And is there a general time in pregnancy when women routinely have an ultrasound?

A. It is very common for women to have ultrasound during pregnancy, and most commonly in the second-trimester, maybe 13 to 20 weeks. If there is any question about dating, it could occur earlier, or there could be a second ultrasound or even a third ultrasound that is done.

The earlier in a pregnancy that you do the ultrasound, the better it is for the dating purposes. But you really need to do it a little bit later in the second-trimester if you are going to look for anomalies and things like that.

Q. When you say "dating," you mean to determine the gestational age of the fetus; is that right?

[20]

A. That's right.

Q. And what sorts of anomalies can be detected with ultrasound?

A. With ultrasound we can detect some apparent birth defects. So things like anencephaly, which is the absence of the brain.

The ultrasound is very good at detecting that. Things like abnormalities of the kidneys or the heart, it's not a hundred percent accurate, but it will pick up abnormalities like that.

Q. Now, what about the chromosomal anomalies that you were describing, how are those detected?

A. Those are detected through amniocentesis or chorionic villus sampling.

Q. And what is amniocentesis?

A. Amniocentesis is a method of obtaining a sample of amniotic fluid from the pregnancy sac by inserting a needle through the abdomen into the amniotic sac.

Q. And do pregnant women routinely have amniocentesis?

A. Not all pregnant women, no.

Q. Why is that?

A. Because it does carry some risks, so it tends to happen only—it tends to be recommended only in women who have risk factors for fetal anomalies. The incidence of fetal anomalies in general population is low, so it is not—it's not indicated to do amniocentesis on all women.

Q. So under what circumstances do the benefits of the [21] amniocentesis generally outweigh the risks of doing it?

A. The benefits outweigh the risk when a woman, pregnant woman has risk factors for a fetal anomaly. It may occur, for instance, if the woman is a little bit older

in age. Older women have increased risk for certain birth defects.

Another example would be if a woman had a family history of a particular type of genetic defect, then it would be indicated in that situation.

There are also situations where the ultrasound won't show a defect, a birth defect, but it will show things like too much amniotic fluid or too little amniotic fluid, and you worry that that may be an indicator of a chromosomal abnormality, so you would do amniocentesis in that case.

Q. What is the typical gestational age at which amniocentesis is performed?

A. Sixteen to 18 weeks. Although, it may be performed later if one of those ultrasound indicators like the too much fluid, too little fluid occurs, because I have seen ultrasound—amniocentesis done in the third-trimester if there is a suspicion by ultrasound that there may be a genetic defect associated with those ultrasound findings.

Q. How long does it take for the results of amniocentesis to come back, on average?

A. Minimum seven days. It can take two to three weeks.

Q. So Dr. Paul, you have testified that some maternal [22] conditions tend to worsen as pregnancy progresses, and other conditions don't develop until the second-trimester. And you have also testified that many anomalies can't be detected until the second-trimester. Does this mean that abortions for maternal or fetal indications are more likely after the first-trimester of pregnancy?

MR. QUINLIVAN: Objection, your honor, leading.

THE COURT: Overruled.

THE WITNESS: Yes.

BY MS. GARTNER:

Q. Dr. Paul, do you have an opinion on the relative safety of carrying a pregnancy to term and through childbirth versus having an abortion?

A. Yes, I do. I—of course, many women carry pregnancies to term, and I have been part of their lives in these very joyous times. And I—so most women who are healthy do very well.

But, if you look just at safety data, then carrying a pregnancy to term is more risky than having an abortion.

Q. I would like to break that opinion down a little bit to understand your basis for concluding that. I would like to start first by talking generally about the safety of carrying a pregnancy to term and through childbirth.

In your work, Dr. Paul, do you regularly review data on the safety of pregnancy?

A. Yes, I do.

[23]

Q. And from what sources are the data that you regularly review?

A. The Centers for Disease Control and Prevention, or the CDC, publish data on pregnancy mortality. And there is also data on complications of pregnancy that result in hospitalization.

Also the journals are full of articles about specific conditions that can occur during pregnancy.

Q. When you review safety data, what sort of adverse occurrences do you look at?

A. Both morbidity and mortality.

Q. And what is the difference between morbidity and mortality?

A. Mortality relates to death, and morbidity relates to complications.

Q. And based on your knowledge of the literature in this area, what is your opinion about the overall safety of carrying a pregnancy to term in terms of mortality?

A. Carrying a pregnancy to term does carry a risk of death, albeit small. The current pregnancy-related mortality rate in the United States is about seven to eight per 100,000 live births. However, that rate is increased for certain groups of women, like older women, African-American women.

Q. And based on your knowledge of the literature in this area, what is your opinion about the overall safety of carrying a pregnancy to term in terms of the morbidity?

A. There are data that look at hospitalizations during [24] pregnancy as an indicator of pregnancy complications. And the data show—the most recent data show that there are about 12 hospitalizations for obstetrical complications per 100 deliveries. So it is quite a high rate.

Q. So does that mean that 12 percent of women that carry pregnancies to term are hospitalized before they give birth?

A. The denominator is deliveries, not women. So it is a little bit complicated. That is a simplified way of putting it, yes.

It really says that every 100 deliveries that occur, 12 will have admissions before the delivery that are due to pregnancy complications.

Q. And does the safety of carrying a pregnancy to term vary based on maternal age?

A. Yes, it does. In fact, the data—most recent data show that at—in terms of mortality—that at 35 to 39 years old, the risk of dying is about twice that of women who are less than 20 years old. And at age 40 and above, the risk is about five times.

Q. Five times?

A. The risk at less than 20 years old.

Q. Okay. Dr. Paul, can you give us an historical perspective on the safety of carrying a pregnancy to term, including childbirth in this country?

A. Yes. The pregnancy-related death rates have decreased [25] substantially. For example, there were about 850 per 100,000 live births in 1900, and there are seven to eight per 100,000 live births today.

Q. And when you are saying 850 or seven to eight, are those deaths due to pregnancy?

A. Yes.

Q. What is it that has happened to make pregnancy safer in this country?

A. I am not sure it is pregnancy being safer so much as our ability to treat the conditions of pregnancy has improved.

Q. Dr. Paul, I now would like to ask you a little bit about the safety of abortion, generally. Do you review data on the safety of abortion as part of your work?

A. Yes, I do.

Q. And, again, as with pregnancy, do you review both morbidity and mortality data?

A. Yes.

Q. What do you consider to be the most reliable sources for data on abortion-related morbidity?

A. Studies that were conducted by the Centers for Disease Control and Prevention in the 1970's. It was a program called "The Joint Program for the Study of Abortion," or JPSA.

Q. And how were the JPSA studies conducted?

A. The JPSA studies were large, very large, and collectively the JPSA studies included perhaps a quarter of a million. And [26] they were prospective, multi-centered studies, so that they involved numerous hospitals and clinics throughout the United States. And their purpose was to look at complications associated with legal abortion in the United States.

Q. When you say these studies were "prospective," can you explain what you mean by that?

A. Yes, they can be prospective, looking forward in time or in retrospective where the events occurred in the past, and you look backwards to determine if there is any associations between certain conditions and diseases or—certain risk factors and health conditions that you are looking at.

So these were prospective studies, which are generally considered to be better than retrospective studies.

They involved training people at the hospitals to keep track of women from the time that they had their abortion forward, looking forward to whether complications occurred.

Q. And you might have said this, but when were the JPSA studies conducted?

A. From 1971 to 1979.

Q. And who were the lead investigators of the JPSA studies?

A. Dr. Willard Cate directed the program, and Dr. David Grimes was the co-director.

Q And is Dr. David Grimes a co-editor of the text that you were the chief editor of on abortion?

A. Yes.

[27]

Q. And did JPSA publish the results of its studies?

A. Yes, in several articles.

Q. And is there a particular article or source that summarizes the conclusions of the JPSA studies on abortion-related morbidity?

A. There's a few. The one that I like is by Nancy Binkin (Phonetic).

MS. GARTNER: Your Honor, may I approach the witness to hand her this article?

BY MS. GARTNER:

Q. Dr. Paul, I have handed you what is Learned Treatise number 15.

Is this the article that you were referring to?

A. Yes, it is.

Q. And for the record, can you tell me the name of the article, the author, the publication and the date of publication, please?

A. The name of the article is "Trends in Induced Legal Abortion Morbidity and Mortality." The author is Nancy Binkin.

And this was published in "Clinics in Obstetrics and Gynecology" in 1986.

Q. Thank you. I would like to direct your attention, Dr. Paul, to page 8, table 7 of this article.

A. I don't have a page 8.

Q. Oh, I am sorry. I believe it is the last page of the [28] article.

A. Table 7, yes.

Q. Do you see table 7?

A. I do.

Q. Okay, good.

Dr. Paul, does this table summarize the JPSA findings on abortion-related morbidity?

A. Yes.

MS. GARTNER: We are attempting—what always seems to fail is the technology to put this up on the screen.

Your Honor, we have a technology person.

THE COURT: Certainly.

(Pause in the proceedings.)

THE COURT: While he is doing that, generally we don't publish the exhibits until they have been admitted into evidence. As I understand it, both sides have learned treatises they are going to use with their experts but are not going to move them into evidence; is that correct?

MR. QUINLIVAN: That's correct.

MS. GARTNER: That's correct.

THE COURT: So I am assuming there is no objection to the projection, even though—of these items, even though they are not going to be admitted?

MR. QUINLIVAN: No objection to the projection, but we will have an objection if it is being moved into evidence. [29] But we don't have an objection as to the projection.

MS. GARTNER: Yes, and we don't plan to move it into evidence, your honor.

THE COURT: All right.

BY MS. GARTNER:

Q. Dr. Paul, referring specifically to this table, can you tell me—along the top it says "JPSA I, JPSA II and JPSA III," with roman numerals. Can you tell me what the difference is between JPSA I, JPSA II and JPSA III?

A. They were three phases of the JPSA studies. The time intervals, which you can see, at which they were done were different. They also involved different subjects, different women and different institutions.

Q. Okay. What does this table tell you about the JPSA findings with respect to abortion-related morbidity?

A. May I use the pointer?

Q. Yes.

THE COURT: Yes.

THE WITNESS: Thank you.

You see the table is entitled: "Major Complication Rates per 100 Procedures Based on JPSA Studies."

Here it shows the type of procedure in the left-hand column, and the rates in the rest of the columns. So, what it shows is that for first-trimester suction curettage, which is another name for vacuum aspiration, the rates were about 0.2 to [30] 0.6 per—and that is a percent. So 0.2 to 0.6 percent. For induction methods that were used at the time, which saline instillation, and this is called prostaglandin instillation, the rates ranged from 1.7 percent to 3 percent.

And for D&E abortion, the rates ranged from 0.6 percent to 0.9 percent.

BY MS. GARTNER:

Q. And, again, when you say "the rates," that is the rate of major complications; is that correct?

A. That's right.

Q. And in the JPSA studies, what was considered to be a major complication of abortion?

A. JPSA collected data on 15 different serious types of complications, but most of them fell into three different major complications. And they are shown

down here: a fever that is sustained for three or more days; hemorrhage requiring transfusion; and unintended major surgery: abdominal surgery, hysterectomy, major surgery.

Q. And did the JPSA studies consider retained placenta to be a complication of abortion?

A. Yes, but not a serious one.

Q. And, Dr. Paul, are the abortion methods that were assessed in the JPSA studies the same ones that are used today?

A. There are significant differences.

Q. How were the D&E methods used today different than the ones [31] that were used at the time of the JPSA studies?

A. The main difference is in the way we dilate the cervix.

Q. And how are the induction methods used today different than the methods that were used at the time of the JPSA studies?

A. We use different types of medications and different groups of administration.

Q. Given the differences in how abortions are done today, in your opinion is it valid to rely on the JPSA studies in assessing abortion-related morbidity?

A. I think it is because JPSA established the Foundation for Abortion Safety. It is the largest data set available on complication rates from legal abortion in the United States.

There is just nothing that rivals it.

Q. In your opinion, is there a difference in the abortion-related morbidity today than there was at the time of the JPSA studies?

A. I can only speculate, but because our methods have improved I would assume that abortion safety has also improved for all methods.

Q. Does JPSA still exist as part of the CDC?

A. No.

Q. Why does it no longer exist?

A. It was discontinued because the question that it had been designed to answer about abortion safety after legalization of abortion had been answered. It showed unequivocally that [32] abortion was a safe procedure.

Q. And are there any additional recent studies looking at abortion-related morbidity?

A. Yes, there are articles in journals that mostly are single—come from a single institution, and they are smaller, but they generally confirm the safety of abortion.

Q. And, Dr. Paul, what do you consider to be the most reliable data on abortion-related mortality?

A. The CDC data.

Q. And is that data different from the JPSA CDC data?

A. Yes. The CDC has an accurate surveillance program for identifying deaths related to both pregnancy and abortion.

MS. GARTNER: Your honor, may I approach the witness to hand her another article?

THE COURT: Yes.

MS. GARTNER: Thank you.

BY MS. GARTNER:

Q. Dr. Paul, I am handing you what is Exhibit 63. Can you tell me, Dr. Paul, what this document is?

A. This is an article that summarizes the information on abortion mortality collected by the CDC from 1972 to 1987.

Q. And is this article prepared by CDC personnel?

A. Yes, it is.

Q. And is it based on data collected by the CDC?

A. Yes, it is.

[33]

MS. GARTNER: Your honor, we would move to introduce this Exhibit 63 into evidence under the public records and vital statistics exceptions to the hearsay rule, which are Federal Rules of Evidence 8038 and 8039.

THE COURT: Any objection?

MR. QUINLIVAN: Just a moment, your honor.

Your Honor, we do have an objection. My understanding is that this was not published by CDC. If it was published by CDC, we would not have an objection. If that is clarified, I'll withdraw the objection. But my understanding is that this paper was not published by the CDC.

THE COURT: All right.

MS. GARTNER: Your honor, I think that is correct, that it was published in the journal, "American

Journal of Obstetrics and Gynecology." However, the exception states that the documents that are exceptions to the hearsay rule include—and I am reading now from 8038:

"Records, reports, statements or data compilations in any form of public offices or agencies setting forth the activities of the office or agency."

And it goes on. So it does say "in any form," and Dr. Paul has testified the authors of this article are all employees of the CDC. And the data reported in this study is all data that was collected by the CDC as a public agency. So we would say this falls within the exception.

[34]

THE COURT: All right. And you became aware of this particular item through the journal, as it was published in the journal?

THE WITNESS: Yes, I did.

THE COURT: All right. Anything else on the matter?

MR. QUINLIVAN: Nothing more on this.

THE COURT: I think it is not precluded by section 8 and it clearly isn't by section 9, so I will permit it.

MS. GARTNER: Thank you, your honor.

THE CLERK: Sixty-three into evidence.

(Plaintiff's Exhibit 63 was received in evidence.)

BY MS. GARTNER:

Q. Dr. Paul, is the data contained in this article the sort of data that you regularly review in your work?

A. Yes.

Q. And how is the data in this publication compiled?

A. The CDC, as I testified earlier, has an active surveillance system to identify abortion-related deaths. That means that it goes to great lengths to identify deaths and uses several sources to do that, including vital records, death certificates of the states, medical examiner reports, health care providers, media reports.

There is about 10 different sources that they use to ascertain the deaths.

[35]

Q. Dr. Paul, just for shorthand, can we refer to this publication as Lawson, or the Lawson publication?

A. Lawson is the first author, yes, so that is fine.

Q. Dr. Paul; I would like to direct your attention to table III, roman numeral III of this article which appears on page 1368, which is also the table that is—that appears on the screen.

Can you summarize what this table tells us about the risk of death from abortion in the time period covered by this article from 1972 to 1987?

A. Again, if I can use my pointer.

The table is case fatality rates, which is the same as death rates, which is the number of legal induced abortion deaths per 100,000 legal induced abortions.

And I do want to clarify that "induced" is being used in a very generic way here. It is not referring just to induction abortion. "Induced abortion" is a very generic term that is used sometimes for all methods of abortion.

So it is the case fatality rates for legal induced abortion by type of procedure and length of gestation, United States, 1972 through '87. And across here is the different gestational ages. And these are the types of procedures.

But in order to summarize, I would direct attention to this figure of one, which is the overall death rate from all methods of abortion. It is one per 100,000 procedures. So it [36] is very low.

And the other thing in general that you notice is that the death rate increases as gestational age increases.

Q. Are you looking for that at the bottom line, the total?

A. The total, yes. So these are the—this is the total death rate from—at eight wee' or less, from all types of procedures that are done at that gestational age.

And the death rate is 0.4 for 100,000. Whereas, if you look at 21 weeks or greater, again, the rate is 10 per 100,000 procedures.

Q. Does the Lawson article tell us whether the risk of death from abortion has changed in the period since abortion was legalized nationwide in 1973?

A. It's not reflected on this table, but the article tells us, yes, that the risk of death has decreased over 90 percent, from about four per 100,000 in 1972, to about 0.4 in 1987.

Q. Dr. Paul, earlier when you were discussing the safety of carrying a pregnancy to term and through childbirth, you said that as women get older the risk for carrying a pregnancy to term increases; is that correct?

A. That's right.

Q. Is the same thing true for abortion?

A. No.

Q. Is that reflected in the Lawson article?

A. When they looked at the most recent period of 1983, 1987, [37] there was—which is our most recent data—there were—there was no association between the age of a woman and her risk of death from abortion.

Q. And then, Dr. Paul, to summarize all of your testimony about abortion-related morbidity and mortality, what is your opinion on the overall safety of abortion?

A. That it is very safe.

Q. Now, you've just been testifying about the overall safety of pregnancy through childbirth and the overall safety of abortion. Based on the various data you have been testifying about, what overall conclusions do you draw about the relative safety of abortion and pregnancy continued through childbirth?

A. The conclusion I draw is that overall abortion is safer than carrying a pregnancy to term and going through childbirth.

And that's based on both mortality data over all the risk of childbirth—of death from childbirth is about 10 times that the risk of having an abortion.

And if you look at second-trimester, that under 16 weeks gestation that the risk of having an abortion is clearly less than the risk of carrying a pregnancy to term.

At 16 weeks gestation and higher, the rates are about the same. But for older women, the rates of

dying from pregnancy and childbirth are higher than the risk of having an abortion. I would say that includes in the second-trimester.

And then,-in terms of complication rates, the data [38] that I talked about in terms of hospitalization show that it's very common to have complications occur during pregnancy. And that when you look at that morbidity data that, in my opinion, hands down abortion is a safer option than carrying to term.

Q. Thank you.

Now, Dr. Paul, I would like to ask you some questions about how often abortions are performed and at what gestational ages they tend to be performed. Are there agencies that collect and compile data about abortion?

A. Yes.

Q. What are those agencies?

A. The Centers for Disease Control and Prevention, and the Alan Guttmacher Institute.

Q. What is the Alan Guttmacher Institute?

A. It's a private, independent research institute based in New York City.

Q. Can I refer to that as AGI? Will you know what I am referring to?

A. Sure.

Q. Which of these organizations, CDC or AGI, is generally understood as having the most complete data on the numbers of abortions performed in this country overall?

A. The AGI. The CDC even acknowledges that the AGI has the better data on that particular aspect of abortion.

Q. And what is the most current year for which AGI has data on [39] the number of abortions in this country?

A. In the year 2000.

Q. And according to that data, how many abortions were performed in this country in the year 2000?

A. About 1.3 million.

Q. And do either the CDC or AGI collect data showing the frequency of abortions at particular gestational ages?

A. Yes, the CDC does.

Q. Where is that published by the CDC?

A. In a publication called "Morbidity and Mortality Weekly Report," or MMWR.

MS. GARTNER: Your honor, may I approach the witness?

BY MS. GARTNER:

Q. I am handing you Exhibit 7, Dr. Paul. Dr. Paul, is this the document that you were referring to a moment ago?

A. Yes, it is.

Q. And for the record, can you state the full name of this document?

A. It's entitled: "Abortion Surveillance-United States, 2000." And it's the "Morbidity and Mortality Weekly Report" of November 28th, 2003.

Q. And does the CDC publish "Morbidity and Mortality Weekly Reports" on other things, in addition to abortion?

[40]

A. Oh, yes, on many conditions, pregnancy-related and not pregnancy-related.

Q. And do you routinely review the MMWR as part of your work?

A. Yes, I have an online subscription.

Q. And as far as you know, is this the most current MMWR related to abortion?

A. Yes, it is.

Q. And how does the CDC compile the data in this report?

A. From state health departments and the health departments of New York City and the District of Columbia.

MS. GARTNER: Your honor, we would move to introduce Exhibit 7 into evidence again, under the public records and reports and vital statistics exceptions to the hearsay rule.

THE COURT: And does the government continue its objection?

MR. QUINLIVAN: Given that it is published by the CDC, we don't have an objection, your honor.

THE COURT: Thank you. Admitted.

THE CLERK: Seven into evidence.

(Plaintiff's Exhibit 7 was received in evidence.)

BY MS. GARTNER:

Q. Dr. Paul, I would like to direct your attention to page 16, table 1 of this exhibit, which Ms. Parker is also putting up on the screen. [41] Dr. Paul, is this the table in this document, the MMWR document, where the frequency of abortions at different gestational ages is discussed?

A. Yes.

Q. Can you tell us generally what information is contained in this table?

A. Yes. The table is called "Characteristics of Women Who Obtained Legal Abortions, United States." Challenged in seeing that far 1973 to 2000.

It's part of a larger table. What this is is the information on the gestational ages at which abortions are done.

So, on the left here you have the weeks of pregnancy, the weeks of gestation divided into different intervals. And these are the different years for which the data is collected. And this is the column for the year 2000, which is the most recent year.

Q. Okay. And in general, what does this table tell us about the gestational ages at which abortions are performed?

A. That most of them are performed in the first-trimester.

Q. And specifically, what does this table tell us about the percentage of abortions that were performed prior to 13 weeks LMP in the year 2000?

A. You have to do a little adding of the columns here. But if you add up the figures here for less than 13 weeks, you get [42] about 88 percent.

Q. And what does this table tell us about the percentage of abortions that were performed between 13 and 15 weeks in the year 2000?

A. You can see that directly on the table, that about 6.2 percent of abortions were performed between 13 and 15 weeks gestation.

Q. And what percentage of abortions were done between 16 and 20 weeks gestation?

A. 4.3 percent.

Q. And what percentage of abortions were done after 20 weeks in the year 2000?

A. 1.4 percent.

Q. So I am going to challenge your math abilities a little more, Dr. Paul. You previously testified that there are approximately 1.3 million abortions in this country in the year 2000; is that right?

A. Yes.

Q. So looking at table 1, out of the 1.3 million total abortions, approximately how many were performed in the year 2000 after 16 weeks LMP?

A. Approximately 74,000.

Q. And after 20 weeks LMP?

A. Approximately 18,000.

Q. Dr. Paul, what I would like to do now is to give the court [43] an overview of the different methods of abortions that are available for women to choose from. First of all, what are some of the factors that determine what methods of abortion are available to a woman to choose from?

A. The gestational age of the pregnancy is probably the biggest, but also the availability of a trained provider for the particular methods.

Q. And are all abortion methods generally available throughout the United States?

A. No. There is a shortage of providers in the United States such that about 87 percent of counties in the United States have no abortion provider. Where there is an abortion provider it is more likely that the provider is trained in first-trimester abortions instead of the later abortions.

And where there is a second-trimester provider, it is more likely that the physician is trained in induction abortion rather than D&E.

Q. Dr. Paul, you said that gestational age is the most important determinant of what methods are available to a woman.

So I want to follow up on that. What methods of abortion are available to a woman in the first-trimester of pregnancy?

A. There's early medical abortion methods that basically involve giving medication to cause the pregnancy to stop growing and to be expelled from the uterus, and there is vacuum aspiration abortion.

[44]

Q. And can you describe briefly what vacuum aspiration abortion is?

A. It is using a source of suction to evacuate the uterus. It can be manual vacuum aspiration, just a syringe-like device that we use to create the suction, or it can be an electric pump that creates the suction.

Q. And what methods of abortion are available in the second-trimester of pregnancy?

A. D&E abortion, dilation and evacuation, which can occur either through disarticulation or as an intact procedure. And there is induction abortion, which is basically giving medications to cause labor contractions to have the woman expel the fetus.

Q. And, Dr. Paul, is there a particular term that you use to describe D&E's that occur by intact extraction?

A. I say the word "intact" D&E. I think it is really just a variant of D&E, so I wouldn't necessarily always identify them separately.

In the textbook when we have a section on it we refer to it as "intact D&E."

Q. And when you say "the textbook," are you referring to your "A Clinician's Guide to Medical and Surgical Abortion"?

A. Yes, I am.

Q. Dr. Paul, if you know, do some doctors use the term D&X to describe abortions in which the fetus is removed with intact [45] extraction?

A. I have seen that used in various ways. I mean, I have heard physicians use it generically to be pretty synonymous with intact D&E.

I do know that ACOG had a specific definition in a publication that it had described something that was much more specific, but I find that it is not really uniform the way that people use that term.

Q. Dr. Paul, when you say "ACOG," is that the American College of Obstetricians and Gynecologists?

A. Yes, it is.

Q. In your opinion, are intact D&E or D&X a distinct procedure from D&E ?

A. Not in my opinion. I consider them a variance of D&E.

Q. Dr. Paul, where are most—where are most D&E procedures performed?

A. In clinics.

Q. And is that an outpatient type setting?

A. Yes, a nonhospital-based outpatient clinic.

Q. And where are most induction abortions performed?

A. In hospitals.

Q. And why is that?

A. Well, induction abortion involves giving medications to put a woman into labor, which can happen over several hours, sometimes even takes a day or two. So—and there are some [46] side effects that occur. So in order to be able to give the woman the medications to induce the labor in addition to give her medications to help with the pain that she may be having during the contractions and to treat side effects that can occur, like nausea, vomiting or fever, monitoring in a hospital is important over that extended period of time. And clinics are not set up to do that kind of longer term monitoring.

Q. Now, if for some medical reason a woman who was having a second-trimester abortion couldn't have either a D&E or an induction procedure, are there other abortion methods that are available to her?

A. There is hysterotomy or hysterectomy. They are methods that are available, although the death rates from them, in my opinion, are prohibitively high.

Q. Can you just describe briefly what hysterotomy and hysterectomy are?

A. A hysterotomy is removal of the pregnancy through an incision in the uterus, and so you do an abdominal incision to get to the uterus, and then another incision in the uterus to remove the pregnancy.

And hysterectomy is removal of the entire uterus, in which case the pregnancy is also removed.

Q. And are those, hysterotomy and hysterectomy, are those commonly performed in this country?

A. No, they are very uncommon, thank goodness. Overall, they [47] are about 0.01 percent of all abortions and about 0.07 percent of second-trimester abortions.

Q. Dr. Paul, are there data showing what percentage of abortions are performed by each available method at particular gestational ages?

A. Yes.

Q. And who collects that data?

A. The CDC.

Q. And is that part of the CDC abortion surveillance document that we were just looking at?

A. Yes, it is.

Q. Dr. Paul, if you would like to turn back to Exhibit 7, which you should have there still to page 32.

Is table 18 on page 32 the data that you are referring to?

A. Yes.

Q. Can you explain the information that is contained in this table, please?

A. Yes. Title is "Reported Legal Abortions by Known Weeks of Gestation and Type of Procedure."

And on the left-hand column here is the type of procedure. Across the rows we have the gestational ages increasing from left to right. And then, the data is in the rest of the table.

Q. And what is meant on this table? I'm looking at the [48] left-hand column, it says:

"Intrauterine saline instillation, intrauterine prostaglandin instillation and medical."

What procedure do those refer to?

A. Those are different methods of induction abortion that were used at the time.

Q. And that all three of those are induction abortions?

A. Yes, they are.

Q. And where—

A. Although, I—yes, that's right. There is a footnote in this table that indicates that "medical" involves primarily the use of vaginal prostaglandins, which is a method for use to induce an induction abortion.

Q. And where in this table are data for D&E reflected?

A. Under "curettage." So the D&E's would be the curette abortions that were done at 13 weeks or greater. So, that's how the CDC categorizes them.

Q. And are data for intact D&E abortions reflected in this table?

A. Not separately. But as I said, intact D&E is a variant of D&E, so I strongly suspect that there are intact D&E's that are included in this—these data, as well as D&E's that proceed by disarticulation.

Q. Looking at these data for 16 to 20 weeks gestation, what percentage of abortions were done by D&E versus what percent [49] for inductions?

A. At 16 to 20 weeks gestation about 95 percent were done by D&E.

Q. Is that—I am sorry. Just to be clear. It is a little hard to read. Are you there pointing to the number of 94.6?

A. 94.6, yes. This 16 to 20; is that what you are asking?

Q. Yes.

A. So 94.6, which I am rounding off to 95 percent. About 95 percent were done by D&E abortion, and about 5 percent by induction.

Q. And then, looking at these data with respect to all abortions after 20 weeks gestation, the same question: what percentage of women had D&E versus what percent had induction abortions?

A. Those data are right here. About 85 percent had D&E abortion, and about 15 percent had induction abortion at 21 weeks or greater.

Q. Dr. Paul, we have gone through a lot of background information, but now I would like to focus in on the particular methods of abortion that would, in your opinion, be affected by the law at issue in this case.

So why don't we identify what those are? In your opinion, would any of the first-trimester methods that you described ever be affected by this law?

A. Not in my opinion.

[50]

Q. And in your opinion, would hysterotomy or hysterectomy abortions every be affected by this law?

A. No.

Q. In your opinion, would the D&E method ever be affected by this law?

A. Yes.

Q. And in your opinion, would the induction method ever be affected by this law?

A. It could be.

Q. Why don't we start by talking about the D&E abortions?

What I would like you to do is to explain in greater detail how you perform a D&E. And start with telling us in general what are the primary components involved in a D&E abortion?

A. There are two primary components. One is cervical preparation, and the other is evacuation of the uterus.

MS. GARTNER: Your honor, with your permission we have some charts or diagrams that may be helpful. Thank you.

Your honor, are those placed in a way that you can see it?

THE COURT: I can see it.

THE WITNESS: May I step down, your honor—

THE COURT: Sure.

THE WITNESS: —if I need to?

BY MS. GARTNER:

Q. Dr. Paul, what I would like you to do is explain to the [51] court why it is necessary to prepare the cervix for a D&E abortion. And if it is helpful to you, you know, feel free to use one of these diagrams.

A. I think I will use this diagram over here to illustrate that. This is the uterus (indicating). The uterus—as you can see, this is a nonpregnant uterus. It is a pear-shaped organ, and it has a narrowing that happens down here at the neck. That is called the cervix.

The cervix has some length. There is something called the external os, which is the external opening that's right at the top of the vagina.

And then, there is the internal os, which is at the other end of the cervix.

Q. And what is the distance, on average, between the internal os and the external os?

A. It certainly can vary, and especially during pregnancy. But it can be as much as 3 inches. It can be as little as 1 inch.

Q. And I am sorry to interrupt you. And then, what is it—if you can explain to us why the cervix needs to be prepared for the D&E abortion.

A. So the cervix is normally closed. It's the entrance into the uterus where the pregnancy is. And our goal in doing any abortion is to get something larger, which is the fetus, out of something smaller,

which is the cervix, without causing injury [52] to the cervix.

So in order to do that, it's necessary to prepare the cervix before you try to bring out the fetus. And that means to dilate the cervix, soften the cervix, get it ready, basically, for the evacuation.

Q. Thank you.

You mentioned two things: dilating the cervix and softening the cervix. What are the ways that you use to dilate the cervix?

A. I would say that there are ways that I use to prepare the cervix, because each method will do some dilation and some softening. So it is kind of a blurring of those, so I just want to be clear about what I am saying. And that is: what are the methods that I use to prepare the cervix?

One of them is the use of osmotic dilators, and the other is the use of medications to prepare the cervix.

Q. Thank you for that clarification. Why don't we talk first about the osmotic dilators. Can you explain what that term means?

A. An osmotic dilator is a short stick of compressed seaweed or synthetic material that is placed into the cervix. It absorbs fluid from the cervix and vagina, and expands, kind of like a dried piece of seaweed on the beach expands when it gets wet and gradually stretches the cervix open.

MS. GARTNER: Your honor, I have a laminaria. Would [53] you object if I handed it to Dr. Paul?

THE COURT: Sure.

BY MS. GARTNER:

Q. Dr. Paul, is that a laminaria?

A. Yes, it is.

THE COURT: Laminaria being what? May I see it?

THE WITNESS: So this is an example of a laminaria. It's one type of osmotic dilator. It is made of compressed seaweed.

BY MS. GARTNER:

Q. And do laminaria come in different sizes?

A. Yes.

Q. And what size is this one?

A. This is a large.

Q. And when you say—when you say "they come in different sizes," do they come in different lengths and different widths or—

A. Different widths.

Q. Can you describe how you insert the laminaria into the woman's cervix?

A. Yes. First I do an examination, get an idea of—just to be sure that things are fine in terms of the size of the uterus, the position of the uterus, where the cervix is located in relation to the vagina. I then insert a speculum, which is what we use when we do Pap smears and general gynecological [54] exams to visualize cervix, so it is a small instrument that we put into the vagina and open up, and the cervix comes into view.

I then wipe off the cervix with an antiseptic solution. And sometimes I will put a little numbing

medicine around the cervix to make the insertion more comfortable.

I then use an instrument to grasp the laminaria, and I put the laminaria into the canal. So I am putting it through that external os and up the canal and into that—just a little passed that internal os.

Q. And I think you may have said this, but what is it about the laminaria that causes dilation?

A. They absorb fluid and expand and stretch the uterus, the cervix open.

Q. And how many laminaria do you use?

A. As many as will comfortably fit without forcing.

Q. And does that number vary by the gestational age of the pregnancy?

A. Well, I have minimum criteria by gestational age. So that, you know, it is important, for instance, at 14 to 16 weeks gestation, I would want at least two large laminaria. At 16 to 17, a minimum of three. And then, at 17 to 18, six, a minimum of four. But I really want to emphasize the minimum, because in my opinion the more you can get comfortably in without forcing the better.

[55]

Q. Okay. And do you ever do a second insertion of laminaria for one patient?

A. Very rarely.

Q. And how long do you leave the laminaria in place before you begin the evacuation part of the procedure?

Q. It can vary, again, by gestational age, but generally at 16 weeks and over we leave the laminaria in overnight.

Q. And can you predict the amount of dilation you will achieve with the laminaria?

A. No.

Q. Why is that?

A. Because women cervixes just differ, and there is just great variability in the amount of dilation you can get in different women, given the same number of laminaria inserted.

Q. And how do you determine if the dilation that you've achieved is sufficient to continue with the procedure?

A. I need enough dilation to get the instruments in that I use and to have some extra mobility to be able to move those instruments.

So the instruments that I use on the gestational ages I do are 16 to 17 millimeters in diameter. So I am going to want, you know, 18 or more millimeters as a ballpark.

Q. In your opinion, in doing a D&E, is it possible to achieve too much cervical dilation?

A. Not in my opinion.

* * * * *

[57]

BY MS. GARTNER:

Q. Dr. Paul, I think I had just asked you whether in doing D&E abortions and preparing the cervix if it is

ever possible to achieve too much cervical dilation, in your opinion?

A. Not in my opinion.

Q. And why is that?

A. Because the more dilation that I have, the easier the evacuation is, and usually the faster, too.

Q. If dilation is so beneficial, why don't you routinely dilate more than you do now?

A. Well, I already said that I put in as many laminaria as I can that will comfortably fit without forcing. And that generally gives me the amount of dilation that I need to accomplish the abortion safely at the gestational ages that I do it.

If I am going to do more dilation, I would need to bring the patient back for a second set of dilator insertions, which would be—which would delay the abortion by 24 hours. And as you weigh kind of the factors it just doesn't make a lot of sense for the gestational ages that I do to do two sets of dilator insertions.

Q. And at what gestational age do you begin using overnight laminaria before the abortion?

A. Sixteen weeks.

[58]

Q. So, you said that osmotic dilation is one of the ways you prepare the cervix; is that right?

A. That's right.

Q. What are some of the other ways that you prepare the cervix for the evacuation?

A. The other main way is to use a medication called misoprostol?

Q. What is misoprostol?

A. It is a prostaglandin agent. And prostaglandin agents can cause some contractions, and they also affect the substance of the cervix in a way that softens it.

Q. I don't know if you can describe briefly how that works.

A. You mean, how—how it works?

Q. Yes.

A. Well, the cervix is made up of fibers called "collagen fibers" that are kind of cross-linked, and it affects the fibers in a way that makes the cervix softer. And it also causes contractions, of course, which helps to dilate and soften the cervix.

Q. And how is the misoprostol administered to the woman?

A. In various ways. It can be administered through the vagina, just placed into the—they are little white tablets that we place into the vagina. They can be swallowed. And they can be placed in the cheeks. That is called buccal administration, or under the tongue, which is sublingual [59] administration.

Q. And in your practice, how do you administer misoprostol?

A. Buccal administration.

Q. And just for the court reporter, could you spell "buccal," please?

A. B-U-C-C-A-L.

Q. And when in relation to the evacuation part of the procedure do you administer the misoprostol?

A. We generally administer it about 90 minutes before the abortion. There's a range. It can be 90 minutes to three hours.

Q. And do all women respond to cervical ripening with misoprostol in the same way?

A. No. Once again, there is a lot of variability in women's response to the cervical ripening.

Q. After you have given the woman the misoprostol, do you allow her to leave the health center?

A. No.

Q. Why is that?

A. Because women can get contractions and actually have a simultaneous abortion. They can actually miscarry, which we don't want to have happen at home. It has been reported in the literature if you use it the night before an abortion that women can actually expel a fetus at home, and we don't want that to happen.

[60]

Q. And, Dr. Paul, I think I should have asked you this before, but after you insert the laminaria when you are using laminaria in an overnight setting, after you have insertd [sic] the laminaria, can the woman leave the health center with the laminaria in place?

A. Yes. She can carry out her normal life.

Q. You said that the fetus, that the misoprostol can result in the fetus being expelled; is that correct?

A. That's correct.

Q. Does it sometimes happen that the fetus is completely expelled from the woman as a result of the misoprostol?

A. Yes, I have had that happen.

Q. Does it sometimes happen that the fetus is partially expelled from the uterus as a result of just the misoprostol?

MR. QUINLIVAN: Objection, leading, your honor.

THE COURT: Overruled.

THE WITNESS: Yes.

BY MS. GARTNER:

Q. When that happens, when the fetus is partially expelled, could a part of the fetus past the navel be outside of the uterus?

MR. QUINLIVAN: Objection.

THE WITNESS: Absolutely.

MR. QUINLIVAN: Objection, leading.

THE COURT: Overruled.

[61]

BY MS. GARTNER:

Q. Could a part of the fetus past the navel be outside the woman's body as a result of the misoprostol?

A. Yes.

Q. Could it be alive when that happens?

A. Yes.

Q. In that situation where the fetus is partly expelled simply as a result of the administration of misoprostol, how would you complete the procedure in that circumstance?

A. Well, I would apply traction and pull on the fetus to see if the whole fetus would deliver without any other kind of intervention. If the head was lodged at the internal os and couldn't come through, then I would disarticulate the neck, and then complete the procedure with my forceps, going in to get the calvarium, which is the head of the fetus.

Q. Dr. Paul, for how long have you been using misoprostol for cervical ripening before doing D&E abortions?

A. About three years.

Q. At what gestational ages do you use it?

A. I use it by itself usually between 14 weeks and the beginning of the 16th week. Sixteen to 17 weeks I tend to use overnight laminaria. And then, at 17 weeks and up, I tend to combine the methods, using both laminaria and misoprostol.

Q. So from 16 to 17 weeks you would tend to use only the laminaria; is that right?

[62]

A. Yes, it is like 16—throughout the 16th week. And then, once 17 weeks comes, I tend to use both. It can vary a little bit, depending on if the woman had a lot of deliveries in the past in which case I am going to have to dilate a little easier with my method. So, but, in general, those are my—the protocols that I follow.

Q. Dr. Paul, I would like you now to describe in detail the evacuation part of the D&E procedure. When the woman returns to your health center after the laminaria has been in place overnight or if she has only had the misoprostol, if the misoprostol has been in place for the requisite time period, please describe in detail what you do up to the point where you are going to extract the fetus.

A. I do a pelvic examination again. If she has laminaria, and sometimes I can remove the laminaria during that examination just with my hands. Pelvic examination involves putting two fingers in the vagina, and the other hand on top of the woman's abdomen and kind of trying to assess, again, the size and position of the uterus, which is extremely important before you do a procedure. So, when I have my fingers in the vagina sometimes I can just extract the laminaria at that time.

Q. Let me interrupt you. Can you describe what you mean by "The position of the uterus"? [63] And if it helps, feel free to use that.

A. Can I use the diagram?

THE COURT: Yes.

THE WITNESS: I don't know where the pointer went. Anyway, this is a side view of the woman. So here you see this is the bladder from the side (indicating). This is the vagina (indicating). And this, again, all we have is a nonpregnant uterus in the diagram. This is the uterus, and this here is the cervix (indicating). These are the bowels back here (indicating). So as you can see, there is a natural angle that occurs between the vagina and the uterus. That changes somewhat, of course, as the uterus enlarges. But there is

also a natural angle between the cervical canal and the body, rest of the body of the uterus.

So before I do a procedure where I am going to insert instruments into the uterus, I need to know where the uterus is sitting. This shows the uterus is sitting towards the front of the woman's abdomen. But you can have uteruses that can sit in the middle or you can have the uterus kind of tipped towards the back.

Again, as the pregnancy grows, that can change a little bit. But I have had situations where even in the second-trimester the uterus remains tipped towards the back.

[64]

So it is very, very, very important to know the position of the uterus so you have an idea of which way to put your instruments in so as not to cause injury.

BY MS. GARTNER:

Q. And I am sorry. I interrupted you in midstream. I lost track of exactly what you were saying. I think you were talking about the pelvic exam that you do at the beginning.

A. If I can remove the laminaria at that time, then I do, if it is easy. I then administer pain medications that usually before a second-trimester abortion we will give pain medications and a sedative through an intravenous line. We don't put women all the way to sleep. It's called "conscious sedation." It helps women relax and also decreases the discomfort associated with the procedure. I then insert the speculum into the vagina and visualize the cervix. And I put a grasping instrument called a tenaculum on the cervix to stabilize it, and so

that I can move this sort of layer in the procedure. But I could put a tenaculum, usually, on the cervix.

And then I administer numbing medicine, the cervical anesthesia. And I use a small forcep to remove the laminaria, if they are in place.

Q. And, Dr. Paul, can you explain again why you use the tenaculum on the cervix? What do you do with the tenaculum?

A. There is a couple of things you can do. As you are pulling [65] out the laminaria, it holds the cervix still so that the whole uterus isn't moving with you as you are trying to get out the laminaria, right? And during the evacuation procedure especially I use it to draw the cervix as far down to me, towards me as possible, towards the opening of the vagina. So, I use it for mobility to be able to move the uterus around, move the cervix around during the evacuation procedure.

Q. Dr. Paul, before you do anything to move the cervix, what is an average length or an average distance from the opening of the cervix that's closest to the vaginal opening—to the vaginal opening?

A. It can really vary. It really—I really can't say that there is an average length. It may be sitting just a couple of inches up from the vaginal introitus. It may be four or five inches up. So it can vary.

Q. And you used the term "vaginal introitus." What is that?

A. The opening of the vagina.

Q. When you say that you use the tenaculum to pull on the cervix, how far can you bring the cervix down towards the vaginal introitus?

A. It varies, but frequently it is very close to the vaginal introitus.

Q. Do you try to avoid the circumstance where it comes close to the vaginal introitus?

[66]

A. No, I mean, I like when it comes close to the vaginal introitus. It allows me to see better, and to—it brings the cervix closer to me, so it makes it easier for me to insert my instruments. And the importance of it is that it helps to straighten out those angles so that you can get your instruments in easier.

Q. And when you say "those angles"—

A. The angles of the uterus that I was referring to when I was at the diagram.

Q. Dr. Paul, is there anything else you do before you actually begin the evacuation?

A. No. I have given the numbing medicine, given the medicine through the IV, clean off the cervix with an antiseptic solution.

Q. What is the first thing you do to evacuate the uterus?

A. I break the bag of water, either by just breaking it and allowing it to drain, the fluid to drain out, or using suction.

Q. And what is the bag of water?

A. It is the amniotic sac, is the technical term for it. It is the fluid in which—it is the sac in which the pregnancy is located.

Q. And I interrupted you. You were saying that sometimes you use suction to break the bag of waters?

A. Yes. Sometimes I will insert a suction cannula it's called [67] with a little tube attached to suction that breaks the bag and sucks out the fluid.

Q. And when you begin the evacuation, is the fetus ever alive?

A. Yes.

Q. How do you know that?

A. Because I do many of my procedures especially at 16 weeks under an ultrasound guidance, so I will see a heartbeat.

Q. Do you pay attention to that while you are doing the abortion?

A. Not particularly. I just notice it sometimes.

Q. So after you've broken the bag of waters and the fluid is either drained or you've suctioned out the fluid, what do you do next?

A. I evacuate the fetus.

Q. And can you describe how you do that?

A. Yes. I do it using an instrument called forceps. So I insert the forceps and grasp the fetus and pull. That's all the while putting traction on the tenaculum to straighten out that angle. And sometimes the fetus comes out in pieces, and I make instrument passes until the entire fetus is evacuated. And sometimes the whole fetus will come down into the vagina, at least as far as the head.

Q. Okay. Does it ever come out completely without the head becoming lodged?

[68]

A. Rarely it does.

Q. And, in general, what is your objective in evacuating the uterus?

A. My objective is to empty the uterus in the safest way possible.

Q. Is there any advantage to doing the evacuation quickly?

A. Yes, quickly and safely is best. But if you can do the procedure expeditiously, there are some advantages, the biggest being that you have less bleeding and shorter duration of discomfort for the woman.

Q. Why is there less bleeding if the procedure takes less time? Where is the bleeding coming from?

A. Well, if the placenta has detached at all, then there is blood vessels there that can bleed. And the key thing is that the uterus can't contract well to seal off blood vessels and stop bleeding until it is empty.

Q. Okay. Talking now about the situations where the fetus comes out in parts, how many instrumental passes does it typically take to empty the uterus?

A. There is no typical. It could be as many as—as little as two or three or as many as 10 to 15.

Q. And do you have a goal for how many passes it will take?

A. As few as possible.

Q. And why is that your goal?

A. Because every time you pass a forceps into the uterus, [69] there is a small risk of injury.

Q. And can you explain how that would happen?

A. Yes. You can get a laceration of the cervix or a perforation or laceration of the uterine wall with the instruments.

Q. And would that still be a possibility if you were doing the procedure under ultrasound?

A. Yes.

Q. When the procedure goes in such a way that the fetus is drawn out in parts, how does the disarticulation of the fetal parts occur?

A. It occurs because you have the fetal part drawn outside of the cervix, and then there is a counter-pressure that occurs at the internal os. And when you pull, the—it disarticulates that part.

Q. So, is the part that is being disarticulated inside the uterus or outside of the uterus at the moment of disarticulation?

A. Outside.

Q. Can it be outside the woman's body?

A. Yes.

Q. And you had said that sometimes when you apply traction to the fetus it comes out intact up to point where the calvarium lodges; is that correct?

A. Yes.

[70]

Q. In that circumstance, what do you do to complete the procedure?

A. Well, there are two things you can do. You can disarticulate at the neck, or what I prefer to do is to just reach in with my forceps and collapse the skull and bring the fetus out intact.

Q. So when you—in the first scenario where you disarticulate, would you consider that to be an intact D&E?

A. No.

Q. Do you have a preference in your medical practice between D&E's that result in disarticulation and D&E's that result in intact extraction of the fetus?

A. I absolutely prefer intact extraction.

Q. Can you explain why that is?

A. Because it involves fewer instrument passes, and as I explained earlier, each instrument pass there is a small risk of injuring the uterus. And because it is faster, generally.

Q. When you are performing a D&E, when you are beginning to apply traction on the fetus to bring it out, do you take steps to try to keep the fetus as intact as possible?

A. If I know I have good dilation and I reach in and the fetus starts to come out and I think I can accomplish it, the abortion with an intact delivery, then I use my forceps a little bit differently. I don't close them quite so much, and I just gently draw the tissue out attempting to have an intact [71] delivery, if possible.

Q. Just to be clear about this, in those situations where you are able to bring it out intact, but the calvarium lodges at the os, why does it lodge there? Why can't you just extract the entire fetus?

A. It is the biggest part of the fetus. Sometimes the dilation isn't enough for it to come through.

Q. In your practice, Dr. Paul, how often do you perform D&E's involving intact delivery to the point where the calvarium lodges at the cervix?

A. I am guessing, because until this case happened I didn't pay much attention to it. It was just a variation of the way I did D&E. But I am guessing 1 to 10 to 1 to 20 maybe of the procedures I do.

Q. Of the D&E procedures?

A. Yes, of the D&E procedures.

Q. What determines whether the procedure will proceed with disarticulation versus whether there will be an intact extraction?

A. It's primarily the amount of dilation.

Q. And before beginning the procedure, can you predict if you will have enough dilation to bring the fetus out with an intact extraction?

A. No, I can't.

Q. But if you have enough dilation to do so, do you attempt [72] that?

A. Yes.

Q. Dr. Paul, you've said that the one of the reasons why you prefer the intact extraction is because of the reduction of instrumental passes; is that correct?

A. Yes, that's one reason.

Q. Are there other advantages in your opinion in bringing the fetus out intact?

A. I mentioned that it tends to be faster, and therefore you may have less bleeding and less discomfort for the patient. Also, what I find advantageous is that I know I have removed the whole fetus. When you do a

disarticulation D&E, you know, sometimes it is not as easy to tell that you have all of the parts. So, if I have an intact fetus, I know I have removed that entire pregnancy.

Q. What happens in a disarticulation D&E if some tissue actually does remain in the uterus?

A. You can get bleeding or infection.

Q. And do you think it is possible to leave some tissue in the uterus even if you are doing the procedure under ultrasound guidance?

A. I think it is possible to leave a small part or to leave part of the placenta.

Q. And would even a small piece of tissue or placenta result in possible complications?

[73]

A. Yes. I have always been surprised of how little it takes.

Q. Dr. Paul, how long does the evacuation part of the D&E take when the fetus is disarticulated in the process?

Q. It really varies, but generally 10 to 15 minutes.

Q. And what is a typical length of the evacuation part of the procedure if the fetus remains intact?

A. It is usually much quicker. I have had it happen in a minute or two.

Q. In your medical practice, Dr. Paul, have you personally ever perforated a woman's uterus in the process of doing a D&E abortion?

A. Yes.

Q. And has it ever happened that you've perforated a woman's uterus in circumstances where you extracted the fetus intact or relatively intact?

A. It has only happened a couple of times, but it hasn't been—those two times was not associated with an intact extraction.

Q. You testified earlier, Dr. Paul, that the fetus can be alive when the evacuation begins; is that correct?

A. That's right.

Q. When in the course of the abortion does the fetus—does fetal demise occur?

A. I don't know for sure. I certainly know that if I deliver intact and collapse the skull that demise occurs.

[74]

Q. After the evacuation part of the procedure is complete, what do you do to complete the abortion?

A. I use suction to remove any placenta that may be left in the uterus. I also use an instrument called a curette. It is a little spoon-like instrument just to gently go over the walls of the uterus and just be sure that anything feels—the uterus feels empty.

Q. Dr. Paul, I am going to ask you some questions about the impact of this law on your medical practice.

MS. GARTNER: And, your honor, we have a blowup of the act, if you don't mind.

THE COURT: Sure.

BY MS. GARTNER:

Q. Dr. Paul, this chart contains the operative portions of the law that is at issue in this case. Can you just briefly review it so you can recollect the language?

Dr. Paul, are you concerned about the potential impact of this law on your medical practice?

A. Absolutely.

Q. Can you outline your concerns for us?

A. Well, my overriding concern is that if I continue to practice abortion, second-trimester abortions, in the way I believe is the safest for women, that I could be in prison.

Q. In your opinion, could this law be understood as banning some of the D&E's that you do?

[75]

MR. QUINLIVAN: Your honor, objection. It is our position that question of the interpretation of the law is not something that is subject to expert testimony. That is a subject that the court will consider after arguments by both parties. But it is not something that is properly subject to an expert's opinion.

MS. GARTNER: Your honor, I think it would be helpful—and obviously the final determination on this is your honor's—but I think it would be helpful for Dr. Paul to explain how she used these terms and how she thinks that these terms, which are not necessarily clear on their face, would apply to her specific medical practice and how she does abortions.

THE COURT: I am going to permit it.

MS. GARTNER: Thank you.

BY MS. GARTNER:

Q. Dr. Paul, could this law be understood as banning some of the D&E's that you do?

A. Yes.

Q. If you look at the law, it states that: "The term 'partial-birth abortion' means an abortion in which the person performing the abortion deliberately and intentionally vaginally delivers a living fetus." Do you see that language?

[76]

A. Yes.

Q. What does the term "vaginally delivers" mean to you as an ob/gyn?

A. "Vaginally delivers" means the fetus comes out through the vagina.

Q. And what does the term "living fetus" mean to you?

A. Well, "living" could be when there is a heartbeat detected on ultrasound, which could be as early as five weeks gestation. "Fetus" usually applies to the products of conception at 10 weeks and up. So if I put the two together, I would say a fetus at 10 weeks gestation, or more, that has a heartbeat.

Q. And you said that the term "fetus" was used beginning at 10 weeks gestation; is that right?

A. Ten weeks LMP, yes. Before that the products of conception are known as an embryo.

Q. In your mind is the term "living fetus" equivalent to the term "viable fetus"?

A. Absolutely not.

Q. In the D&E's that you do, do you ever deliberately and intentionally vaginally deliver a living fetus as part of the procedure?

A. Yes.

Q. Dr. Paul, continuing reading in this definition, it says that—just to repeat what we have already gone over—that:

> "The abortion occurs such that the physician [77] deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother."

Do you see that?

A. Yes.

Q. When the law says that "any part of the fetal trunk past the navel" is outside the body of the mother, what do you understand that to mean?

A. Well, it could mean a couple of things. One is that the fetus has come out far enough that the fetal body above the navel is outside of the cervix. The other—outside the body of the mother. And the other is that if you were to disarticulate a fetal part that was above the navel, like a limb with part of a shoulder, I would think that that would also apply.

Q. So, just to be clear about that, as you read this law, does the fetus have to be delivered intact up to the point where the calvarium lodges at the cervix for a violation to occur?

A. No.

Q. Does it have to be brought out intact to any point for a violation to occur?

A. It has to be brought out—one scenario is that it's [78] brought out past the navel intact. And the other is that, as I say, to disarticulate a part above the navel, and then continue to put your forceps in to deliver the rest of the fetus.

Q. And in doing D&E's do you ever deliver the fetus to the point where part of the fetal trunk intact with the rest of it is outside the body of the mother?

A. Yes.

Q. Do you ever deliver the fetus such that a disarticulated part of the fetal trunk past the navel is outside the body of the mother?

A. Yes.

Q. And does that ever happen when the fetus is still living?

A. Yes.

Q. Dr. Paul, continuing to read this definition, it says that the fetus is—just to summarize it—is brought outside the body of the mother to the point we have just discussed:

> "For the purpose of performing an overt act that the person knows will kill the partially-delivered living fetus."

Do you see that language?

A. Yes.

Q. Let me ask you first, do you understand the term "overt act"?

A. Not really.

Q. I will just leave that. In those circumstances that you've [79] just described to me in doing a D&E where

the fetus has been brought out in a way that could be described as being to a point where a part of the fetal trunk past the navel is outside the body of the mother, what do you do to complete the abortion?

A. I either disarticulate at the neck, or I put my forceps in and collapse the skull and complete the delivery.

Q. And in your opinion, would those steps be lethal acts that the fetus couldn't survive if it were alive before you did them?

A. I have no doubt that collapsing a skull or disarticulating at the neck would cause fetal demise.

Q. And then after taking those steps, either collapsing the calvarium or using disarticulation, do you then complete the procedure?

A. Yes.

Q. In the abortions that you have done where this has occurred where you brought the fetus out intact up to the point where the head lodges at the cervix, did you deliver the fetus to that point for the purpose of compressing the calvarium?

A. Of course not. I did it to empty the uterus.

Q. Dr. Paul, now that we have gone through the act in this way, are you still concerned about the impact of this law on your practice?

A. Oh, absolutely.

[80]

Q. Do you find any comfort in the "for the purpose of" language in this statute, given that you've told us that you don't bring the fetus out to that particular

point for the purpose of collapsing the calvarium or disarticulating at the neck?

A. I find no comfort in that. I mean, I know what my purpose is. That my purpose in bringing the fetus out past the navel, the fetal trunk out past the navel is to empty the uterus in the safest way possible. Yet, this language implies that I have this other purpose, which is to kill the fetus. So, to me, it's like—kind of like there is an elephant in the room besides me and my patient. It is not just me being allowed to do an abortion in the way that I think in my medical judgment is safest for a woman, but there is somebody judging what my purpose is in bringing the fetus out a certain way. And I don't feel like I can practice medicine well being second-guessed by a third party about what my purpose is in completing and in doing a certain act during an abortion when that person also has the power to put me in prison.

Q. Thank you.

MS. GARTNER: Your honor, may I put up a second chart?

THE COURT: Yes.

BY MS. GARTNER:

[81]

Q. Dr. Paul, this is actually the beginning part of the statute that we have been discussing. And this is the portion of the law that contains the life exception to the act, which is stated in the second sentence in that paragraph. Could you just read that to yourself, please? And, Dr. Paul, when you were teaching in a staff position at the University of Massachusetts Medical

Center, did you perform abortions for maternal health conditions?

A. Oh, yes.

Q. And was that a regular part of your practice there?

A. Yes.

Q. In your opinion, would the life exception to this law enable physicians to perform abortions in all situations where a pregnant woman's life is at risk from continuing the pregnancy?

A. No, it is not how I would interpret this language.

Q. What—why do you think this wouldn't cover all situations where a woman's life was at risk from the pregnancy?

A. My objection really revolves around that word "necessary." It says that:

> "This subsection does not apply to a partial-birth abortion that is necessary to save the life of a mother."

But it doesn't say who decides if it is necessary. There is nothing that says "is necessary within the judgment of [82] a treating physician."

It just says "necessary." So who determines if it is necessary? And is it possible that, again, a physician who is treating a woman could be second-guessed about that decision that it was necessary?

The other thing that I have a problem with with this is that it says "that it is necessary to save the life of a mother."

Well, there is always the alternative of hysterotomy and hysterectomy. But in my opinion, that is not a real alternative for women because of the high rates of morbidity and mortality that are associated with that procedure.

Q. Dr. Paul, earlier this morning you testified generally about the overall safety of second-trimester abortions and the relative safety of abortion and carrying a pregnancy to term. But we didn't focus specifically on the relative safety of the different second-trimester abortion methods. I would like to just go over that briefly with you. And talking first about the morbidity associated with the different second-trimester abortion methods. And I would ask you to look back at the exhibit there that is the Binkin article, which was Learned Treatise 15.

Dr. Paul, can you tell me what conclusions the JPSA studies reached about the relative safety of D&E and induction abortions?

[83]

A. As you can see from this table here, these are major complication rates for 100 procedures. So this is a percent. And these are the induction methods here (indicating) instillation, saline instillation, prostaglandin instillation (indicating). And this is the D&E method (indicating).

As you can see, in general, the rates of major complications by JPSA study were lower for D&E than they were for the instillation, induction abortion methods that were used at that time.

Q. Dr. Paul, can you draw any conclusions from the JPSA studies about the safety of D&E abortions in

which the fetus was extracted intact or relatively intact?

A. Well, JPSA didn't analyze that separately. It is my opinion that—again, because I consider intact delivery just a variant of D&E—that if you had a quarter of a million women involved in the JPSA studies that you definitely had cases of abortions in which the D&E was accomplished with intact delivery.

Q. And then, Dr. Paul, I would like you to look again briefly at the Lawson article that we discussed earlier, which is Exhibit 63, which will be on the screen now.

In this article, if could you focus your attention on table roman numeral III, on page 1368, which is here (indicating). And, again, the Lawson data, is that mortality data for abortion?

[84]

A. Yes.

Q. And does this table contain a summary of the CDC data on abortion-related mortality broken down by what procedure was performed?

A. Yes, it does.

Q. And what do these CDC data tell us about the relative mortality of D&E and induction abortions prior to 16 weeks gestation?

A. Again, these are case fatality rates or death rates expressed as the number of abortion deaths per 100,000 legal-induced abortions.

And here, evacuation they separate out D&E. They call it "evacuation" here. And then, you have the instillation methods, are which are the induction

methods that were used again at the time of the JPSA study of the—at the time that this was collected.

And what you see here is that prior to 16 weeks, that evacuation has a lower risk of death than instillation.

And at 16 weeks and up, the rates are in the same ballpark.

Q. And what do these CDC data tell us about the relative mortality of either D&E or induction compared to hysterotomy or hysterectomy?

A. There's hysterectomy, hysterotomy. And as you can see, the death rates associated with hysterotomy and hysterectomy are much higher. And I would say prohibitively high. There 16 to [85] 20 weeks it is over a hundred deaths per 100,000 procedures.

And here, at over—at 21 weeks and over, it is 274 deaths.

So, they are just incredibly much higher than the death rates associated with the other methods of abortion.

Q. And just to make the record clear, Dr. Paul, in the 16 to 20 week time frame, what is the approximate case fatality rate for D&E and induction abortion?

A. For D&E it is approximately 6.5 per 100,000 procedures; for instillation 7.9, for 100,000 procedures.

Q. What about over 20 weeks gestation?

A. For D&E, 11.9; and for instillation, 10.3.

Q. Now, Dr. Paul, you had testified earlier that the JPSA studies involved older methods of doing D&E and induction; is that correct?

A. That's right.

Q. Are there any studies that specifically compare the relative risks of D&E and induction abortions, as those procedures are currently performed?

A. There's a couple of small studies.

Q. Can you describe those for me?

A. One is by Autry and colleagues. And what they did was a historical cohort study, basically looking back into medical records identifying women who've had a medical abortion, which would be the induction type of abortion and women who had D&E abortion, and then determining what the complications were with [86] those procedures.

And what they found was a higher rate of complications with induction methods than with the D&E. But it had to do mostly with retained placenta, which means that there was quite a high rate of retained placenta associated with the induction abortion that required surgical removal of the placenta through a curettage technique or by manual removal.

They also had one incidence of uterine rochsho (phonetic) associated with the medical induction procedures.

Q. In your practice, Dr. Paul, in providing induction abortions, can you describe briefly what's involved when there's a retained placenta as part of an induction abortion?

A. I did a lot of induction abortions at the University of Massachusetts Medical Center, and the medication was often successful in getting the fetus out, but the placenta remained in the uterus.

Generally, you would wait and wait. And it's kind of standard that if two hours after the delivery of the fetus the placenta has not yet delivered, that you take some kind of intervention to remove the placenta.

So, you could try to remove it manually, it's pretty uncomfortable; you can reach up and try to actually get it with your hands, or you can do basically a suction and curettage removal of the placenta. I know at the university we often put people to [87] sleep to do that. I mean, it was a big deal for women to have gone through a whole labor process thinking they weren't going to have surgery and then end up having to be put to sleep to have the placenta removed.

Q. What are the risks—you said there was a general rule of thumb to remove the placenta after two hours if it hadn't delivered on its own.

What were the risks if the placenta remained inside the uterus longer than that?

A. That's been looked at in the literature, and basically there is an increase incidence of bleeding and fever if you have it in there for longer.

Q. Other than the Autry study, are you aware of any other recent studies comparing the modern methods of D&E with modern methods of induction abortions?

A. There is a small randomized trial by Dr. Grimes.

Q. Is that the same Dr. Grimes who is the co-director of the JPSA studies?

A. Yes, it is.

Q. Can you describe that study for me, please?

A. It was a pilot randomized study—

MR. QUINLIVAN: Your honor, I have an objection. That study was not disclosed in either of the—either the expert report or the rebuttal expert report that was submitted by Dr. Paul.

[88]

MS. GARTNER: I believe that Dr. Paul testified as to this in her deposition.

(Pause in the proceedings.)

MS. GARTNER: Your honor, I apologize, I don't have the page handy. I don't think this is a central point. We have other witnesses who will testify about that study, so we can move forward on that.

THE COURT: All right. Without some reference, you have put the defense on notice to that study, she may not do so. If there is such notice, either in the expert report or the deposition transcript, I would permit it.

MS. GARTNER: I understand, your honor. I believe it was in the deposition, but I don't want to waste the court's time looking for it now.

BY MS. GARTNER:

Q. Dr. Paul, other than the JPSA studies, the Lawson study, and the Autry study that you've just talked about, are there other data or studies that would help to assess the safety of D&E abortions in particular?

A. Well, there are single institution reports of the experience of the institution of doing D&E's and generally confirming safety.

And the same with induction, I mean, there are single institution reports of experiences of random induction.

Q. What do those single institution reports generally show?

[89]

A. They generally confirm that they both are safe procedures, but that induction does have this problem of retaining the placenta very, very rarely during interruption.

Q. Are you aware of any data or studies comparing the relative safety of D&E with intact extraction to other second-trimester abortion methods?

A. No.

Q. In your opinion, is it surprising that there are no studies specifically looking at D&E's with intact extraction?

A. No.

Q. Why is that?

A. First of all, I think it's considered just a valiant, so I am not sure people ought to study it separately, but I—it also would be difficult to set up a study that looked at intact because, first of all, there is not—it would be hard to predict if the fetus were going to come out intact.

So, I am not sure how you would set up a study to really look at that in any kind of good way, and the other thing is, is that because there's—it's a little hard to explain—but basically, to set up a good randomized trial where you're putting women into groups, you know, one getting intact extraction, the other getting

disarticulation of D&E, right, in a way that does not introduce bias, the kind of biases that we see in studies and so forth, you would first have to be able to identify who would get those intact versus [90] disarticulation, I said, that would be hard to predict, but the other thing is that you would need very large numbers in each group in order to see if there was a difference in complication rates. One, because complication rates don't occur that often with abortion, right, complications don't occur that often with abortions, and the other is because the percentage of abortions that are done in the second—beyond the first-trimester are relatively small.

So, that just would make it very, very difficult to set up a really good randomized trial that could give you that information.

Q. Okay.

Is there any requirement in the medical profession that a medical technique be subjected to randomized trial before it's used?

A. No. We like when we have randomized trial, but it certainly is not a requirement before we use techniques.

Q. Are there other aspects of abortion practice other than the intact extraction variant of D&E that have not been subjected to randomized trial?

A. Could you repeat that question?

Q. Yes. Are there other aspects of abortion practice that have not been subjected to randomized trial? And by "other," I mean other than the intact extraction.

[91]

A. Yes. I mean, most of what we do in abortion has not been subjected to randomized trial.

Q. Dr. Paul, what is evidence-based medicine? What does that term mean?

A. Evidence-based medicine is a way of doing medicine that takes into consideration the scientific information that is available.

Q. And under the principles of evidence-based medicine, what should a physician do if there are no studies assessing the safety of a particular technique?

A. Well, basically evidence-based medicine says that if there is good evidence that one particular method should be used, then it is our responsibility to use that method.

But where that evidence is lacking or is inadequate, that we use our best clinical judgment to render the safest care possible to our patients.

Q. So, Dr. Paul, given the comparable safety, what you've testified as the comparable safety of D&E and induction beginning at about 16 weeks gestation, based on your experience providing abortions what are some of the considerations that go into a woman's decision to pick one procedure or the other if she's having a second-trimester abortion?

A. Patient preference go one procedure over the other in my experience and from my reading of the literature. Induction abortion can be pretty trying to women, and women tend to have [92] a preference for the shorter D&E procedure.

Q. Dr. Paul, just to conclude and go back again to the statute in this case, what impact would this law have on your practice if it took effect?

MR. QUINLIVAN: Objection, your honor, asked and answered.

THE COURT: Overruled.

THE WITNESS: Well, I think it would have a tremendous impact on my practice. I would be forced with a decision I would have never faced before in medicine and that is as to whether to continue to do procedures in a way that I think are safest for women because if I did so, I would risk imprisonment.

And I have dedicated a lot of my life and career and been pretty adamant about wanting to provide care to women, so this would be a very difficult personal and professional decision to me—for me as to whether I could continue to do second-trimester abortions.

BY MS. GARTNER:

Q. If this law took effect, would it affect how you teach D&E abortions?

A. I think it would.

I would have to make a decision about whether I could teach all methods, if I could teach about intact extraction, some of the things that might be violated by this [93] law. I would, at the very least, feel a responsibility to inform those whom I am teaching that they could—that they would risk imprisonment if they performed an D&E in a particular way.

Q. And would, if this law were to take effect, would it affect your relationship with your patients in your opinion?

A. Yes. I think fundamentally my relationship with my patients is based on trust, and part of that trust is that I am going to give them the best care possible and I am going to do a procedure the way I deem that is safest at the time. So, that fundamental trust would be compromised.

And there's also a part of the law that says something about that civil action could be taken against me if a spouse—if I didn't obtain the consent of a spouse or, in the case of a teenager, her parents before I did a procedure, that might violate this act.

So, to me, that really violates the most fundamental tenets of patient confidentiality. There is no requirement in California for me to tell a parent about—to get the consent of a parent to do an abortion on a minor. So what's that mean now; suddenly I have to do that?

There is certainly nowhere that the spouse has to give permission for a woman to have an abortion, so the whole thing about patient confidentiality, the whole basis on which [94] my trusted relationships with patients are built is compromised.

* * * * *

[CROSS-EXAMINATION BY MR. QUINLIVAN]

* * * * *

[PAUL—CROSS EXAMINATION]

* * * * *

[103] procedure is safer than the disarticulation D&E procedure is based on your intuition and your clinical experience?

A. On my clinical experience and the clinical experience of all of the physicians with whom I have spoken.

Q. Are you able to quantify in any way the advantage you believe that the intact D&E procedure has over disarticulation D&E?

A. To quantify it, no.

Q. Do you consider that disarticulation D&E's are generally safe?

A. Yes.

Q. And in your experience, how many complications have you had with the disarticulation D&E procedure?

A. I don't recall exactly. I do know that the two cases of perforations I had were with disarticulation D&E.

Q. It's true, Dr. Paul, that with respect to Planned Parenthood Golden Gate, you don't record on your forms whether or not the procedure was performed intact or not; is that correct?

A. That's right.

Q. So, would you be—strike that. Dr. Paul, it's true, isn't it, that there are examples in the medical literature where physicians have thought that a particular procedure was safe and effective * * *.

* * * * *

[105] electronic fetal monitoring actually led to higher cesarean section rates; isn't that right?

A. Universal use of electronic fetal monitoring, yes.

Q. That was not something that anyone had thought of prior to those studies being conducted; isn't that right?

A. People might have thought about it, but they didn't know it.

Q. Dr. Paul, would you agree that if a particular abortion procedure led to a higher rate of cervical incompetence, then other procedures that that would be a complication of the first procedure?

A. If that were proved, yes.

Q. And if you wanted to look at the outcome of cervical incompetence, you would have to follow women through their next pregnancy to determine whether there was any kind of difference in rates; isn't that right?

A. Yes.

Q. Just to be clear, you yourself are not aware of any data that has considered whether the intact D&E procedure might lead to higher rates of cervical incompetence as compared to other procedures, are you?

A. No.

Q. Have you yourself followed up with women who have undergone an intact D&E through their next pregnancy to determine whether their might be higher rates of cervical incompetence?

[106]

A. Well, I don't do prenatal care anymore, so I would not have seen them in the next pregnancy if they carried to term.

Q. The answer is "No"?

A. No.

Q. Is it also—would you agree that if a particular abortion procedure led to a higher term of preterm—

THE REPORTER: I'm sorry. Can you start again?

BY MR. QUINLIVAN:

Q. Would you agree that if a particular abortion procedure led to a higher rate of pre-termed deliveries than other abortion procedures than that would also be a complication?

A. Yes. If you really knew that. If the complication is an odd term to use, generally that is kind of what we call long-term sequelae, it is different than the kind of complications that are typically measured after an abortion procedure.

As you can see from the JPSA study, that's not a complication that was ever looked at. So I just want to be clear on our definitions of complication.

Q. Understood.

And I guess my question is, there can be complications that occur potentially months or years after the abortion procedure, not just right when the abortion procedure takes place; isn't that right?

A. There is no evidence that there is long-term adverse * * *.

* * * * *

[107]

* * * * *

Q. Given what you just testified when I asked you the question about cervical incompetence, you haven't followed through with women who have undergone the

intact D&E procedures to see if that has led to a higher rate of pre-termed deliveries, have you?

A. No. As I say, I probably wouldn't even remember which ones had intact and which had disarticulation D&E because I don't specifically note it on the chart.

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C 03-4872 PJH

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. AND PLANNED PARENTHOOD GOLDEN GATE, PLAINTIFFS

v.

JOHN ASHCROFT, ATTORNEY GENERAL OF THE UNITED STATES, DEFENDANT

TRANSCRIPT OF PROCEEDINGS
Mar. 29, 2004
Volume 1

BEFORE THE HONORABLE
PHYLLIS J. HAMILTON, JUDGE

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* * * * *

[KATHERINE SHEEHAN, M.D. – DIRECT EXAMINATION]

[151]

* * * * *

Q. Good morning, Dr. Sheehan. Have you come to court today prepared to provide your opinions about the partial-birth abortion ban act and its impact on your practice?

A. I have.

Q. Before we get into your opinions, I would like to do a couple of background questions; is that okay? Are you a physician?

A. I am.

Q. In what fields?

A. I'm trained in OB and GYN.

Q. Are there any other fields in which you practice or are trained?

A. I did a Subspecialty Fellowship in Reproductive Endocrinology.

Q. And what is reproductive endocrinology?

A. That is the speciality regarding hormones and having to do with reproduction, male and female reproduction.

Q. And you indicate that your were trained in obstetrics; is that correct?

A. That's correct.

Q. Do you with currently practice obstetrics?

A. I don't.

Q. And why is that?

A. I found that during my training that I really enjoined [152] taking care of women. I enjoyed the actual practice of medicine for women and therefore focused more on gynecology. It also allowed me a little bit more time to raise my family.

Q. Are you board certified?

A. I am.

Q. In what areas?

A. OB/GYN.

Q. And what is your current position?

A. I'm currently full-time medical Director of the Planned Parenthood Affiliate of San Diego and Riverside counties.

Q. And how long have you held that position?

A. Since 1981.

Q. So close to over 20 years?

A. Correct.

A. Can you tell me a little bit about Planned Parenthood San Diego Riverside counties? First of all, how many health care centers does that affiliate have?

A. We have seventeen health care centers.

Q. And where are they located?

A. They are spread throughout the counties of San Diego and Riverside.

Q. And what types of patients does Planned Parenthood San Diego Riverside county serve?

A. We see primarily young healthy people for their contraceptive needs, evaluating pap smears for women and [153] evaluating abnormal pap smears. We also see young men for contraception and for STD testing. We have an HIV screening program.

We also have a midlife program, which is for women of middle age. We have a prenatal program. We have a sterilization program for both men and women. And we have significant abortion program.

Q. And how many patients does Planned Parenthood San Diego Riverside county see each year?

A. We see over a hundred thousand patients.

Q. And as Medical Request Director, are you in charge of—what does your position entail?

A. I am responsible for all the medical care that is provided at the affiliate. I supervise all the physicians and the midlevel clinicians which are nurse practitioners, nurse midwives, physicians assistants.

Q. So you oversee all the medical care and you supervise the various physicians?

A. Correct, and I am responsible for the medical protocols of the operation, the standards that we operate under.

Q. How many physicians does Planned Parenthood San Diego have that you supervise or oversee?

A. We have approximately 11 or 12.

Q. And what about the other medical personnel that you were just talking about?

[154]

A. We have over—probably over a hundred midlevel positions and some part-time positions.

Q. Does Planned Parenthood San Diego Riverside County offer abortions?

A. Yes.

Q. Does it do so at all of the 17 health centers?

A. No. We provide abortion services only at three of the centers, surgical abortion services. I should say we provide medical abortion services at all the family planning centers.

Q. To what gestational age do you provide medical abortions?

A. We provide medical abortion up to sixty-three days or nine weeks.

Q. And you said you provide those at all of the family planning?

A. Family planning.

Q. And what do you mean by medical abortions?

A. I mean, abortions that are induced by giving the women medicine, usually mifepristone.

Q. And you indicated that you provide surgical abortions at three of the health care centers; is that right?

A. Correct.

Q. And what do you mean by "surgical abortions"?

A. I mean abortions that are provided as—by the means of surgery.

Q. And up to what gestational age does Planned Parenthood San [155] Diego Riverside County provide surgical abortions?

A. We provide it up to another twenty-four weeks.

Q. As part of the surgical abortions that you provide, do you provide those due to the presence of a fetal anomaly?

A. We frequently do that.

Q. And why do you do that?

A. Our affiliate has become basically the main referral center for all of California South of L.A. for few anomalies. We receive referrals from the Kaiser-Permanente Group. We receive them from the largest medical groups in that area. Even UCSD refers some of their cases to us.

So we have become basically the primary source for fetal anomaly terminations in that area. We are the only center that goes past 18 weeks in the area.

Q. And that is the only center for all circumstances, including fetal anomalies, or just the fetal anomalies past 18 weeks?

A. I'm sorry. I don't understand.

Q. Well, you indicated you are the only center that provides abortions after 18 weeks gestation in the San Diego area; is that right?

A. There is one other provider who will go past 18 weeks for fetal anomalies.

Q. And do you know what percent of the second-trimester [156] abortions that are performed at Planned Parenthood San Diego are for fetal anomalies?

A. Since we are becoming the sole referral source, our numbers are definitely increasing. I would say it is in the range of 15 to 20, and possibly 25 percent.

Q. And what type of fetal anomalies are referred to Planned Parenthood San Diego?

A. It's across the board. We have had three cases of conjoined twins, we have anencephaly, Potter's Syndrome, which is a condition where the kidneys don't develop. We have certain—Downs Syndrome is the most common, many other genetically-abnormal pregnancies.

Q. What is anencephaly?

A. Anencephaly is when the brain doesn't develop.

Q. And are all those fetal anomalies that you just mentioned chromosomal?

A. No. Some of them are structural, such as the renal agenesis, Potter's Syndrome.

Q. What is renal agenesis?

A. That's where the kidneys don't develop.

Q. And are some of them structural?

A. Yes.

Q. And could you give us some examples of structural fetal anomalies that your affiliate deals with or sees?

A. The lack of development of the kidneys would be one example [157] of that. Another example would be a condition called amniotic bands, when there is not enough amniotic fluid in the uterus and so the membrane becomes bands, and they cut off the circulation for the fetal limbs and so there is no development of the hands or the feet. There is—basically the circulation is cut off, and so the limbs don't develop.

Q. And you also indicated you had recently seen three cases of conjoined twins?

A. I have.

Q. Are there any other structural fetal anomalies that your affiliates have seen?

A. We have seen numerous structural anomalies. Just last week I saw a woman with several anomalies, which were cardiac malformations, hand malformations and formations of the bones of the face.

Q. Are some of these anomalies fatal?

A. Absolutely.

Q. Give me some examples of some of the ones which you've seen that are fatal?

A. Potter's Syndrome is incompatible with life. Anencephaly is incompatible with life. This one that I just mentioned with the cardiac malformations and cystic kidneys is incompatible with life.

Q. So in addition to surgical abortions, does Planned Parenthood San Diego affiliate offer induction abortions?

[158]

A. We don't offer induction abortions.

Q. And why is that?

A. We don't have the physician time it requires keeping a physician at the hospital for many hours, and we just don't have the manpower.

Q. Now, you indicated that you supervise 11 physicians at the affiliate. Do all of those physicians perform abortions?

A. No, two of them do vasectomy.

Q. But the remaining nine do?

A. Yes.

Q. And do all of those physicians perform second-trimester abortions?

A. No, they don't.

Q. How many do?

A. Three.

Q. Do you perform second-trimester abortions?

A. I do.

Q. Is that a significant part of your clinical practice?

A. It is.

Q. And up to what gestational age do you provide second-trimester abortions?

A. Up to 24 weeks.

Q. How do you ascertain that gestational age?

A. The ascertainment of gestational age is not a hundred percent accurate science, but it starts with the woman's [159] history of her last menstrual period, as was mentioned earlier today, and an examination and also an ultrasound evaluation.

Q. Do you use any particular measurements to determine that it's up to 24 weeks?

A. We use as many measurements as we can make using the ultrasound. The primary ones are biparietal diameter. We have diameter circumference and the fetal length—I am sorry—femur length, f-e-m-u-r.

Q. What is the biparietal diameter?

A. That's the distance—

THE COURT: Why don't you spell that word?

THE WITNESS: B-I-P-A-R-I-E-T-A-L. The parietal bones are on either side of the head. The biparietal diameter is from this side of the head.

BY MS. PARKER:

Q. And up to what biparietal diameter do you offer second-trimester abortions?

A. We go up to 56 weeks.

Q. And does your affiliate ever go beyond 24 weeks?

A. No.

Q. And why is that?

A. It has been an interpretation based on the viability issue.

Q. So you indicated that—let me back up. What types of abortions do you offer in the second-trimester at your affiliate?

[160]

A. We provide abortions by suction up until about 16 weeks, and then dilation and evacuation after that.

Q. And what types do you offer, do you personally perform?

A. Both of them.

Q. And approximately how many surgical abortions have you performed in your career?

A. It's a difficult thing to try to compute, but I would guess around 30,000 abortions in my career.

Q. And how many of those were in the second-trimester?

A. I would say approximately 30 percent of them.

Q. You said 30 percent?

A. Right.

Q. So it would be about 9,000?

A. Yes.

Q. Do you have clinical experience performing inductions?

A. I do, during my residency.

Q. Do you currently perform induction abortions?

A. No.

Q. And why is that?

A. As I mentioned before, we just don't have the time to send somebody to the hospital for hours at a time.

Q. And you did do so during your residency?

A. I did.

Q. Approximately how many induction abortions did you do during your residency?

[161]

A. I would say approximately 300.

Q. So in addition to serving as the Medical Director of Planned Parenthood San Diego, do you have any responsibilities with regard to Planned Parenthood Federation of America?

A. I do in that I sit on the national—I have sat on the National Medical Committee, which is an advisory committee made up of experts who advise the Planned Parenthood Federation Board on the medical policy. And I also serve as an affiliate reviewer.

Q. And what do you do as an affiliate reviewer?

A. Twice a year I serve on a group of people who go to the affiliates and review the affiliates' performance primarily in the medical field. Suellen Craig's testimony mentioned the many different factors that are looked at at the affiliates to ascertain if they are providing excellent services that meet the standards of the Federation.

But the physician goes on this committee basically to review the medical services that are being provided at the affiliate.

Q. Is that part of the accreditation process that the Planned Parenthood Federation does at each of the affiliates?

A. That's correct.

Q. It is the medical aspect of that?

A. Correct.

Q. And you are part of that committee?

[162]

A. Correct.

Q. So in addition to those two sort of responsibilities, Medical Director and serving on the medical committee for Planned Parenthood Federation, do you do anything else in your professional capacity?

A. I have a small private practice, as well.

Q. Okay. Why don't you tell us a little bit about that, as well?

A. I have a very nice small private practice for about 12 years in an area near San Diego. And when I was asked to go back to the affiliates as a full-time medical director in 1997, I requested that I be allowed some time to continue my private practice. So one day a week I see my own private patients.

Q. What services do you offer in that practice?

A. General gynecology.

Q. Do you do anything else professionally? Do you teach?

A. Thank you. I am on the faculty at UCSD. I am a clinical faculty member at University of California San Diego. And I teach the residents in the reproductive medicine program. Primarily we teach them abortion

provision. We also have some residents who choose not to go through the abortion program, and they do family planning services.

I also teach the Navy residents in OB/GYN who come to learn abortion services.

Q. And the naval residents, where do they come from?

[163]

A. The U.S. Navy has a residency program in San Diego at the Naval hospital.

Q. Does the U.S. Navy have a medical school in San Diego?

A. No.

Q. Where is that located?

A. Bethesda, Maryland.

Q. Do you do the training at the hospitals or do you do that at Planned Parenthood's clinics or health centers?

A. I do that at the Planned Parenthood centers.

Q. And what do you train the reproductive medicine residents in?

A. Primarily in first and second-trimester abortion care, but also in family planning.

Q. Do you train them how to perform abortions?

A. Yes.

Q. And what particular methods of abortions?

A. We train them in the provision of medical abortion, and early surgical abortion, which we also call

manual vacuum abortion. And we use suction aspiration and dilation and evacuation.

MS. PARKER: Your Honor, may I approach the witness?

THE COURT: Yes.

BY MS. PARKER:

Q. Dr. Sheehan, I show you what has been marked Exhibit 66. Do you see that?

[164]

A. I do.

Q. And what is that?

A. This is my C.V.

Q. Did you prepare it?

A. I did.

Q. Is it current?

A. It is.

Q. Is the information in it accurate and correct?

A. It should be.

Ms. Parker: I would like to offer exhibit 66 into evidence.

THE COURT: Any objection?

MR. SIMPSON: No objection, Your Honor.

THE COURT: Admitted.

THE CLERK: Sixty-six into evidence.

(Plaintiff's Exhibit 66 was received in evidence.)

MS. PARKER: And, Your Honor, I would like to move to qualify Dr. Sheehan as an expert witness in the areas of gynecology, and all areas of abortion practice.

THE COURT: Any objection?

MR. SIMPSON: Your Honor, subject to our questioning her further on cross-examination—

THE COURT: Do you wish to question her now?

MR. SIMPSON: No, not in voir dire; simply in [165] relation to her qualifications on cross. We have no objection to admitting her as an expert.

THE COURT: All right. She will be admitted.

MS. PARKER: You want me to move on?

THE COURT: Yes.

BY MS. PARKER:

Q. Dr. Sheehan, you indicated you were here to provide your opinions on the partial-birth abortion ban act and the impact on your practice; is that right?

A. Correct.

Q. Can you give us a general overview of what those opinions are going to be?

A. My opinion is that the act could strongly inhibit the way I normally practice abortion care for my patients in the later part of the second-trimester.

Q. And do you have any opinions about the overall safety of the procedures that appear to be banned by the act?

A. I feel strongly that abortion care as we provide it in our affiliate, which is to provide the safest possible D&E care, often would violate the understanding or my understanding of this act.

Q. So you indicated that you use dilatation and extraction in the second-trimester; is that correct?

A. Correct.

Q. And do you have a goal when you perform that particular [166] procedure?

A. My goal is to complete the termination of the pregnancy as quickly and safely for the woman as possible.

Q. And how do you do that? How do you attempt to achieve that?

A. One of the crucial things about dilation and extraction is to provide accurate cervical dilation. And this is accomplished over one or two days before the procedure by using osmotic dilators to achieve adequate dilation for the procedure. And then, the procedure itself is done as quickly with as few passes with the forceps as possible, and to get the procedure done quickly.

Q. And what is the purpose of doing it with as few instrument passes as possible?

A. I think the crucial thing to understand about D&E is that you are putting instruments through a small aperture, which is the cervix, into the uterus. It is a totally blind procedure. We do have ultrasound available during the procedure to help guide us, but it is not a perfect adjunct. You're putting large forceps into a blind space to try to extract fetal parts that are larger than the aperture of the cervix. It is a very risky condition, potentially, because if the forceps closes on, you know, the wall of the uterus or perforates through the wall of the uterus and closes on some other organ of the woman, there are serious complications and serious

things happen after [167] that. So, it's—it just makes sense to make that kind of maneuver as infrequently as possible.

Q. And what do you try to accomplish so you can do as few maneuvers as possible?

A. The essential thing is adequate cervical dilation.

Q. And the purpose of adequate cervical dilation is for what purpose?

A. The purpose of adequate cervical dilation is so that I have adequate room to put my forceps in and make the fewest amount of passes to be able to extract the fetal tissue.

Q. And you indicated there were some complications. I think that is the word you used. The more times you introduce the instruments into the uterus; is that right?

A. Correct.

Q. And could you describe what some of those could be?

A. Well, the main thing is allowing the forceps to go past the wall of the uterus. As the pregnancy gets further along in gestation, the wall gets thinner and thinner so it is actually possible to have put the forceps through the wall and not be absolutely certain that you know where you are.

It is also possible to close down those—that instrument on tissue that isn't actually fetal tissue, and then when you put traction on it, you can actually injure the uterus or injure other organs in the woman.

Q. What happens when that occurs?

[168]

A. One hopefully notices it right away; know that you have got a complication. You have to transport the woman to the hospital and perform an open surgery to evaluate the situation and fix it.

Q. And so that's—

THE COURT: Excuse me. Can I ask a question? Do you use the ultrasound with every procedure, every D&E procedure?

THE WITNESS: I do.

THE COURT: Is that standard?

THE WITNESS: I don't believe it is standard. I think in our affiliate it is standard, but when I go around and review other affiliates, it is not.

BY MS. PARKER:

Q. You indicated one of the reasons why you want to have as few instrument passes as possible was to reduce the risk of perforation or laceration?

A. Yes.

Q. Are there any—are there other reasons that you want to have as few instrument passes as possible?

A. The other thing I would say is that if I can do the procedure as quickly and with as few passes as possible then it reduces the anesthesia time. Our patients are deeply sedated to the point of actually being asleep. And this is a potentially risky situation for the woman that if she can't [169] breathe for herself or if she were to vomit and aspirate the contents of her stomach, this can be a potentially fatal condition.

So we try to have the woman under anesthesia as short of a time as possible. So completing the procedure as fast as possible with as few passes as possible is desirable.

Q. And are there other reasons that you can think of why you want to have as few instrument passes in the uterus as possible?

A. Well, each time you pass in and out of the uterus you have the potential of actually cutting the cervix with any of the sharp parts that might be coming out of the uterus, so you potentially raise your risk of laceration.

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[178]

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Q. Before we resume with our discussion of how you perform a dilation and evacuation procedure, I just wanted to ask you a few more brief background questions, if that's okay.

A. Yes.

Q. In addition to your clinic practice at Planned Parenthood San Diego and your private gynecological practice, do you have any hospital privileges or do you ever do anything at any hospitals?

A. I do have, but I consider it a fairly unique situation within Planned Parenthood in that I am a fully fledged attending doctor at the Women's Hospital in San Diego. And so the patients at Planned Parenthood have the advantage of being able to have their pro-

cedures done at the hospital, if there are indications for them to need to be hospitalized and need that higher level of acuity.

Q. And what type of procedures would you do at the Women's Hospital in San Diego?

A. I have every Friday morning reserved for surgeries. [179] Usually they are tubal ligations, removal of ovarian cysts, general gynecologic care. But we can certainly reserve time to do D&E's, as well.

Q. And have you ever testified previously in any case involving an issue about abortion?

A. No.

Q. Have you ever testified previously in a case?

A. No.

Q. So let's now return to our discussion of D&E. Yesterday, you indicated that you performed D&E procedures in the late second-trimester; is that right?

A. Correct.

Q. And what is the gestational age up to which you perform those procedures?

A. Up to 24 weeks gestation.

Q. Do you do the same D&E procedure throughout the second-trimester of abortion?

A. Under 16 weeks I generally use misoprostol to allow a one-day procedure. I also use mainly suction to extract the fetal parts and placenta.

After 16 weeks, uniformly when you have laminaria inserted overnight and have more of an extraction sort of procedure.

Q. Let's focus our discussion on after 16 weeks up to about 24 weeks. Is that okay with you?

[180]

A. Yes.

Q. And I would like to start with how do you start the procedure? What happens when a woman first comes into the clinic who needs a later second-trimester abortion?

A. She goes through the general intake process, fills out her history forms and things like that. She meets with a counselor. She has all the information given to her about the potential procedure.

She has a thorough history reviewed with a clinical person, usually a nurse practitioner, a physical examination, an ultrasound to confirm the gestational age.

Q. Do you give every patient an ultrasound?

A. Yes, every single patient gets an ultrasound.

Q. What happens after the ultrasound?

A. We make a decision about whether we are able to proceed there in the clinic or if she needs to go to the hospital. She has anesthesia risks evaluated. As long as she qualifies for an outpatient surgery in our clinic, then we go ahead and start the procedure, being sure that she has had her informed consent obtained.

And the first step of the procedure is the insertion of the first set of laminaria.

Q. How many laminaria do you insert on the first day?

A. The first day there are two laminaria inserted.

Q. What is the purpose for inserting them on that day?

[181]

A. The process is started in terms of softening the cervix and starting the dilation so that a larger number of laminaria may be inserted at the next opportunity.

Q. How much do the laminaria swell up? We saw one yesterday. I think this one was used (indicating). Can you describe for us how much they swell up?

A. The laminaria start usually at about three or four millimeters of diameter, and they can swell three or four times up to over a centimeter.

Q. That is the first day. What happens after that?

A. The patient is discharged. She goes home. If she feels comfortable enough, she can go about her normal activities. Some of the women have a lot of cramping and have to stay at rest.

She comes back the next day. She is evaluated again. Those first laminaria are removed, and then a new set is inserted.

Q. Do you always use a second set in the later or after 16 or 18 weeks?

A. Our general rule is at 18 weeks there will be a second set of laminaria placed. It isn't always followed, particularly if a woman has a fetal demise. If the fetus has already died inside the uterus, the uterus is much more irritable, and we usually will use just one set of laminaria then.

Q. So you do the second set on the second day; is that right?

[182]

A. Correct.

Q. How many do you insert at that time?

A. It's not an absolute number. Generally, we try to put in as many as would fit comfortably. This is generally in the range of five to eight.

Q. Are you aiming for a particular amount of dilation?

A. There is a goal that we have in the clinic to try to obtain at least a minimum amount of dilation to make the procedure safe. And the rule that we use is that the dilation of the cervix in millimeters should be relatively equal to the gestational age in weeks.

So if the woman is at 20 weeks, then we would like to have 20 millimeters of dilation, or two centimeters.

Q. And can you predict the amount of dilation you will get?

A. It is highly unpredictable.

Q. Is there a minimum amount you need?

A. Yes. Without having adequate dilation, one isn't able to introduce the instruments into the uterus. And so absolutely the cervix has to be dilated an adequate amount.

Q. Can you control the amount of the dilation?

A. No. We try to get an adequate amount of laminaria in, but the laminaria dilate variably based on many factors, primarily what the nature of the patient's cervix is like.

Young teenagers with little, firm cervixes tend to not dilate as easily. A women who has had a delivery or two, [183] the cervix will dilate much more easily.

Q. In your opinion, is it ever possible to get too much dilation?

A. That is a desirable condition to have, plenty of dilation. So, no, I don't think you can have too much.

Q. How long do you leave the second set of laminaria in?

A. Again, overnight.

Q. So, she's had now two sets of laminaria two different days. She comes back, I take it, on the third day?

A. Yes.

Q. And then, is that the day that you start the actual procedure?

A. Correct.

Q. Could you describe for me what happens on the third day?

A. She is taken to the procedure room. An IV is started. She changes out of her clothes. She gets up on the table. It is a normal, like a pelvic exam table that you would go and have your pap smear on.

There is an anesthesia provider there, and anesthesia is begun so the patient can be calm and relaxed and comfortable during the procedure.

A pelvic exam is carried out to, one, remove the gauze and laminaria that have been put in the cervix; and then, also to assess the nature of the cervix, how dilated it is, how soft it is, how effaced it is. "Efface-

ment" is the process of [184] shortening of the cervix. The cervix starts out fairly long, and it opens up along with dilating.

We evaluate the presentation of the fetus, what part of the fetus is presenting at the cervix. I can feel if the cervix is adequately dilated up into the uterus and feel previous cesarean scar, things like that.

And then, we bring in the ultrasound machine and evaluate, again, for the presentation of the fetus.

Q. And, again, do you use the ultrasound with every patient at that time?

A. Yes.

Q. And after—and the ultrasound, you indicate you are doing that to figure out what the fetus presentation is?

A. Correct.

Q. And do you ever attempt to change the fetal presentation?

A. No, I don't. But certain presentations are more difficult to deal with, and I just want to know what I am dealing with.

Q. Okay. So after you have assessed the fetal presentation, what do you do next?

A. Then, a cervical block of local anesthetic is placed around the cervix, and the amniotic sac is ruptured, allowing the amniotic fluid to flow out.

And, then, using the forceps, I begin the procedure of extracting the fetal part.

Q. And how do you go about doing that?

[185]

A. I generally try using the ultrasound to find the small parts of the fetus, "small parts" being considered the extremities. I really prefer it if the lower extremities are presented first. I can grasp the lower extremities of the fetus, and using gentle traction, extract the tissue.

Q. And after you have done that, what do you have? What happens next?

A. I continue to put traction on the fetus tissue. If the cervix is adequately dilated, then the fetus will generally slide down through the cervix, and I continue to extract the tissue until it is completely extracted.

If the cervix is not so well dilated, then disarticulation and dismemberment happens.

Q. And how long—well, after the fetus is removed or extracted, what do you do?

A. I am sorry, how long after?

Q. Well, after you have extracted the fetus—

A. Yes.

Q. —are there any additional procedures that you do?

A. Absolutely. The placenta is usually still in the uterus, although occasionally it comes out first or during the procedure. I make a certain maneuver with the forceps to be able to remove the placenta as intact as possible.

Then, I use an instrument call a "curette." It is an instrument shaped like a long spoon that is introduced into [186] the uterus. It gently scrapes the walls

of the uterus to be sure that there aren't any little fetal parts or any parts of the placenta left behind.

And then, to complete the procedure, I use a suction cannula. It is like a large straw. It is attached to a suction machine, and it is used to just gently aspirate the uterine cavity.

Q. And how long does the entire surgical procedure take?

A. It really depends on how dilated the cervix is and how intact the fetus is as I extract the tissue. If the cervix is very well-dilated and the fetus comes down easily, then it can take just a matter of a few minutes. It can take as long as 10 to 15 minutes.

Q. Are there any advantages to doing the procedure more quickly?

A. Absolutely.

Q. What are they?

A. Well, assuming that the quick one is where the fetus is intact, then you don't have the sharp broken bones of the fetal body that are potentially able to lacerate the cervix as they are extracted, so there is a definite decreased risk to the mother then.

Also, the quicker the procedure, the smaller amount of bleeding that will occur. And then, thirdly, the anesthesia, the entire time that she's asleep under the |187| anesthesia she is at significant risks of aspirating. That is a condition where the stomach contents come back up into the throat, and then they are inhaled into the lungs. It is a life threatening condition. And our anesthesia people are constantly vigilant for such a situation. And being able to wake the patient up very quickly is definitely in her interest.

Q. Do you know when in the course of the D&E procedure that fetal demise occurs?

A. I don't know that.

Q. Do you pay attention to that?

A. I don't.

Q. Why not?

A. My goal is to complete the procedure as safely and quickly as possible, so I am not paying attention to it.

Q. How long have you been doing the D&E procedure in the manner that you just described?

A. I was taught during my residency in the '70's. And I have basically been performing it the same way in all those years, with some modification.

When I went to Planned Parenthood we focused a little bit more on the uniform preparation of the cervix and so that we would be sure we had adequate dilation at the time of the procedure.

Q. So the most significant change you have made to that procedure over the last 20 years is to the dilation aspects?

[188]

A. Correct.

Q. And how have you done that?

A. By consistently using the two days of preparation for the over 18 weeks.

Q. Dr. Sheehan, have you ever had a situation where the fetus comes out intact or partially intact?

A. Yes, I have.

Q. And how often does that occur?

A. It comes out partially intact very frequently; completely intact, less so. Just last week I was working with a resident from UCSD, and we had three of our 12 cases proceed so that the body of the fetus came out completely intact.

Q. Do you have a preference as to whether the fetus comes out intact or partially intact?

A. I definitely do. I prefer it come out intact.

Q. And when—what are the factors that influences that the fetus will come out intact or partially intact?

A. It is the relative sides of the fetus versus the relative aperture of the cervix that it has to come through.

Q. When a D&E results in an intact delivery, would you characterize that as a variant of a D&E, or a different kind of procedure altogether?

A. All the procedures that I am providing to get this request of the patient accomplished are, in my mind, the same procedure. I don't differentiate I am doing x, y or z [189] procedure. It is basically all under the termination to me of D&E.

Q. And are there any situations where you would expressly want to get an intact fetus?

A. There are.

Q. What are those?

A. I just had an example of this about two weeks ago. There was a young woman who came up from Mexico. Her fetal care had begun fairly late, and on an ultrasound it was identified that there were numerous fetal anomalies.

She decided not to take the time to have an amniocentesis, but to come directly to have a termination.

The doctor taking care of her had told her that these anomalies were not compatible with life, and so she was advised to come and have a termination.

In the same request, they wanted to have as much intact tissue as possible so that they could analyze the fetus after the termination procedure so that they would learn more about the condition of the fetus so that they could give advice to this young woman about her future pregnancies.

Q. Do you recall what type of fetus anomalies that fetus had?

A. I had multi cystic kidneys, abnormalities of the facial bones, and a cardiac malformation.

Q. Could you have done an induction under those circumstances?

A. An induction was offered to her. When we discuss options [190] with our patients, this is always an option offered to them. We don't actually provide induction, so if she had elected to do that, we would have referred her for that.

Q. She didn't pursue it. And why was that?

A. She was happy enough for us to tell her that we would do the best job we could to provide her with intact tissue, but we couldn't guarantee it.

Q. Are there any situations where an induction is contraindicated? Before we do that, can you explain for us what "contraindication" means?

A. "Contraindication" means when a procedure or a medicine is—carries more risk than benefit to the patient, so it is ill-advised.

Q. Do you have situations where and induction would be contraindicated?

A. Yes. Induction is usually carried out with prostaglandins. And if the woman has had one or more previous C-sections, the scar in the uterus is considered an area of weakness in the uterus and potential rupture, so women with previous C-sections are generally advised not to have induction.

Q. And are there any other situations you've had where a patient would want an intact fetus that you can think of?

A. It is generally for fetal anomaly diagnosis.

* * * * *

[193]

Q. Dr. Sheehan, do you as a physician have a preference as to whether the fetus emerges intact?

A. I do. I believe the procedure goes more quickly and more safely when the fetus comes out as intact as possible.

Q. Are there situations where you were doing a D&E and there was sufficient dilation to remove the fetus, except for the head?

A. Yes.

Q. And does it happen—how often does that happen?

A. That happens fairly frequently. In fact, I have been working with a resident from UCSD, as I alluded

earlier, and just last week three of our 12 procedures proceeded in this way.

Q. And why is it frequent that the fetus emerges except for the head?

A. The head is the largest part of the fetal body.

Q. And what do you do when that happens? What is your procedure?

A. Typically, I continue to put traction on the fetal body. If it is able to slide through the cervical aperture, then it will. That is rare.

Usually what happens is we need to disarticulate the fetal body at the neck, and then do a compression of the fetal head with a forceps to remove the head.

Q. And can you wait for the fetal head to deliver on its own?

[194]

A. That is not advisable.

Q. Why is that?

A. The patient is under anesthesia, and it would take quite a while for the uterus to labor enough to open the cervix further to allow the fetal head to deliver.

Q. Are there any special risks if the fetus emerges more intact than not?

A. I can't think of any.

Q. What is your overall experience with the safety of D&E? Do you have an opinion about the safety of D&E?

A. I think D&E's are very safe procedure. When discussing it with my patients, I always underline it is a

very safe procedure. It is at least as safe as going to term and delivering a baby. It is probably safer than appendectomy or tonsillectomy.

We actually have been tracking statistics at our Planned Parenthood affiliate for a number of years and have found that the number of complications in second-trimester abortions is actually less than the number in the first-trimester. So it is a very small percentage, less than 1 percent.

Q. And have you ever had a situation where you have had some complications as a result of the D&E?

A. Yes.

Q. What type of complications have you experienced?

[195]

A. We have had perforations and instances of hemorrhage and infection.

Q. And how often have you had a perforation during a D&E procedure?

A. The numbers in our affiliate are usually one or two perforations a year, and we are doing about 2,000 D&E's per year.

Q. So .1 percent, I think, if I do the math?

A. Correct.

Q. And were any of those situations where you were successful in removing the fetus intact?

A. No.

Q. Have you ever have had a retained placenta in performing a second-trimester D&E?

A. Never.

Q. So do you ever use a chemical agent to cause fetal demise?

A. Yes.

Q. What is that agent?

A. The agent is digoxin.

Q. What is digoxin?

A. Digoxin is the name for digitalis, which is a cardiac medicine that is typically used for specific cardiac conditions, most typically heart failure.

Q. And at what gestational age do you use digoxin?

A. We start using it at 22 weeks.

[196]

Q. Why do you choose 22 weeks?

A. We like to prevent an eventuality of a live birth, and because it seems to make the procedure move along a little bit easier on the day of the procedure.

Q. Are patients required to use digoxin at 22 weeks?

A. No. They are definitely given the choice.

Q. And are there any patients for whom you would not recommend digoxin starting at 22 weeks?

A. There is a group of heart conditions that are considered conduction defects, where the electrical conduction that pulses through the heart is abnormal.

A particular instance of that would be Wolff-Parkinson-White Syndrome where digoxin would be contraindicated, because it could potentially increase the dysfunction of the electrical conduction in the heart.

Q. Have you ever used digoxin before 22 weeks?

A. I have.

Q. And what are those circumstances?

A. It has been in a situation where the patient actually requested it.

Q. But you don't generally use it before 22 weeks; is that right?

A. No, I don't.

Q. And why is that?

A. It would be an additional unnecessary procedure that would [197] potentially add risk to the procedure.

Q. And what kind of risks are there?

A. Risk of infection or risk of going into labor early.

Q. Have you ever seen a woman who became infected as a result of a digoxin injection?

A. I have.

Q. Can you describe that for us?

A. I have seen one patient that I am fairly certain had infection. She had what is described as chorioamnionitis, which is generalized infection of the membranes inside the uterus around the fetus.

In another case where I was suspicious that she was infected because of the administration of digoxin, mainly because she had a fever.

Q. And you indicated digoxin causes fetal demise; is that right?

A. Correct.

Q. Does it cause it in every single time it is administered?

A. No, it is not 100 percent uniformly successful.

Q. And why is that? Do you have any sense of why it is not uniformly successful?

A. We administer the digoxin with a needle through the abdominal wall of the woman into the uterus. We are aiming to get it into the fetal heart, or at least into the fetal thorax. However, we are not able to do that every time. If we are not [198] able to do that, then we attempt to put the digoxin into the amniotic fluid. And it seems to work less often when it is just put into the amniotic fluid.

Q. What percentage of time are you successful in getting the digoxin into the fetal heart?

A. I would say approximately 50 percent.

Q. And when do you administer—when do you administer the digoxin when you use it?

A. The day before the procedure.

Q. And why do you do it then?

A. We started doing it on the first day of laminaria, and we found too many women were going into labor early.

Q. So you now do it 24 hours in advance of the actual procedure?

A. Correct.

Q. Do you know when it takes effect?

A. I have not looked at that.

Q. Have you ever used a chemical agent called "KCl," or "potassium chloride" in the context of the D&E procedure?

A. No.

Q. So, let's see.

MS. PARKER: May I approach just for collection of the—

BY MS. PARKER:

[199]

Q. Dr. Sheehan, at the beginning of our testimony yesterday you indicated you were going to testify also about the partial-birth abortion ban act and the impact in your practice. Do you remember that?

A. Yes.

Q. And I've put up here a section of that act. Do you see that?

A. I do.

Q. And have you seen that before?

A. Yes.

Q. When did you see it?

A. When the act was passed.

Q. Are you concerned about the potential impact of this law on your practice as you've described it this morning?

A. I am very concerned.

Q. Why are you very concerned?

A. Because as I've discussed, it is frequent and preferred that I do something that is described in this act, which is that the fetus is delivered, in the case of a breech presentation, to the—any part of the fetal trunk is past the navel. So I am afraid that what I do meets the description here in the act.

Q. And in addition to the impact on your own practice, do you have other concerns about the impact of the act?

A. I am very concerned. I have heard a number of providers [200] discussing that they would find it difficult to continue providing second-trimester abortion care if this act actually went into effect.

Q. And would that create any problems if people cease doing second-trimester abortion care?

A. Absolutely. It would make it more difficult for women who are seeking these procedures to actually get them. There probably would be a delay in accessing the care.

And we know that every week that a woman waits further into gestation, her risk of complication goes up by 50 percent. So it is essential that women seek the care as soon as possible.

Q. And why exactly would this act impact on your practice, on how you perform your procedures?

A. Well, I would be concerned about the attention that I have been placing on obtaining excellent cervical dilation, because that part of the process which I believe creates the safety of the procedure would be also putting me in the position of violating the act.

So I would feel like I would have to consider not dilating as far, which would not be preferable, because that is the safety—the safety feature of my procedure.

Q. And do you know what the term "deliberately and intentionally" means?

A. I don't understand it. I know a little bit of grammar, and [201] I know those are adverbs, and they

should be modifying the verb, which is "delivers." So "deliberately and intentionally delivering," that is what I do. That is what I am trying to do in my procedure.

Q. And what about the term 'living fetus," what does that mean to you?

A. It would be a fetus that still has a heartbeat, and that would still apply to many of my cases.

Q. And in your practice do you bring the fetus to the point where the fetal trunk past the navel is outside the body of the woman?

A. Yes, I do. That's what I mainly do.

Q. And that happens often?

A. Yes.

Q. And you have a preference for that?

A. I do.

Q. In your opinion, could this law be understood as violating D&E's for disarticulation occurs?

A. Yes, that is possible.

Q. And how would that happen?

A. If a disarticulation procedure had started, but the fetus then was delivered to the level of the navel, it could still be living. The heartbeat could still be going, and the fetus would have already had a disarticulation procedure started.

Q. And have you encountered those situations in your practice?

|202|

A. Yes.

Q. Do you know what the term "overt act" means?

A. Not really.

Q. Now, you understand that there has been an injunction entered in this case, and right now the act is not being enforced; is that right?

A. Yes.

Q. If the injunction were lifted, do you know what you would do with your practice?

A. I would have to consider long and hard how we are providing D&E's. The evolution of the process that we are doing now has been based on trying to achieve the highest safety for our patients, so we would have to consider each part of the preparation and the procedure to try to avoid violating the ban.

MS. PARKER: May I also get another?

THE COURT: Yes.

BY MS. PARKER:

Q. So, Dr. Sheehan, I would like to show you another portion of the Partial-Birth Abortion Ban Act, which is known as the "Civil Action Provisions." Do you see that which is before you?

A. I do.

Q. Have you seen that before?

A. I have.

[203]

Q. And that provision states that if the father is married to the mother at the time she receives a partial-birth abortion procedure, and if the mother has not attained the age of 18 years at the time of the abortion, the maternal grandparents of the fetus may, in a civil action, obtain appropriate relief, unless the

pregnancy resulted from the plaintiff's criminal conduct or the plaintiff consented to the abortion.

Do you see that?

A. Yes.

Q. And that indicates essentially that if the father or maternal grandparents of the fetus could sue, right, if they don't give consent to the procedure?

A. Yes.

Q. Do you currently obtain consent for the abortion from the father?

MR. SIMPSON: Your Honor, I am afraid we have to object to this line of questioning. I don't believe that there is any allegation in the complaint regarding this provision.

THE COURT: And so your objection is irrelevant?

MR. SIMPSON: Exactly.

THE COURT: Okay.

MS. PARKER: But this goes to the impact of the act if it is not enjoined on her practice.

THE COURT: I actually want to hear from all of the positions by both sides about their opinion as to the impact. [204] I will permit this line of questioning.

And you may ask your experts the same questions, if you wish to do it.

BY MS. PARKER:

Q. Dr. Sheehan, do you currently obtain consent for the abortion from the father?

A. I don't. The decision to obtain an abortion is a very private matter between the patient and me, her physician. So I don't ask the permission of anybody else.

Q. And do you ever obtain permission from the maternal grandparents of the fetus if the mother is not yet 18?

A. That would be my patient's parents, and, no, I don't ask their permission.

Q. And if the act went into effect would you have to change your practice in that regard in terms of the consent you obtain for the procedure?

A. I would.

Q. Are you concerned about that?

A. I am very concerned about that. I see patients in a number of situations where this would really cause a significant disruption in the relationship between the patient. And the women who come in for second-trimester procedures particularly are in some sort of chaotic situation in their lives.

Frequently maybe their husband is just leaving them. They are not in good relationships with their families. And to [205] have to obtain the consent of somebody who is not looking out for the patient's best interest would definitely cause a problem.

MS. PARKER: Thank you, Dr. Sheehan. I have no further questions at this time.

THE COURT: I just have a few questions before you start question, counsel.

With regard to the procedure that you use when the fetus is delivered pretty much intact and the head is

lodged, is the procedure that you describe, the disarticulation of the neck, the only procedure that you use in that scenario?

THE WITNESS: It is not the only procedure. If the cervix is adequately dilated and effaced so it is thin, I can sometimes get one of the forceps around the fetal head to compress it without actually disarticulating.

THE COURT: Okay. And is the preparation of the cervix the same regardless of whether or not the procedure is a D&E or intact D&E?

THE WITNESS: I don't differentiate those two procedures. I set out to do a D&E to obtain the termination of the pregnancy of the patient, so I don't really consider my self doing intact D&E. If that happens as part of the process, then I'm actually relieved, because it reduces the risk for the patient.

But, it's all part of the same continuum to me.

[206]

THE COURT: All right. So is it appropriate for me to assume, then, from your testimony that you have no control over whether or not the extraction is going to be intact or partial?

THE WITNESS: You're exactly right. This is something that happens as we evaluate the cervix at the beginning of the procedure. The woman has already gone through two days of preparation of the cervix. It is not until that moment when she is already lying on the table and asleep when I am able to evaluate what the dilation of the cervix is.

So it is at that moment that I am able to have more information and can make a judgment about how the procedure is going to proceed at that point.

* * * * *

[KATHERINE SHEEHAN, M.D. - CROSS EXAMINATION]

[231]

Q. That was not my question. Is it true, doctor, we have talked about when the physician is attempting disarticulation, I have asked you whether there are certain maneuvers that the physician uses with the forceps to do that.

Now, I am asking about the other side of it. When the physician is attempting to remove the fetus intact, are there certain distinct maneuvers that the physician uses?

A. They are basically the same maneuvers, as long as the fetal parts are low and you are attempting to reach those.

Q. If I could have you turn to your deposition, doctor. The whole part, the main part, not the confidential part. Page 101, please.

If I could ask you to read, doctor, to yourself page 101, line 22 through page 102, line 8.

Have you read that?

A. Uh-huh.

Q. Thank you.

If I could read that to you, page 101, starting on line 22.

And I should say first this question refers to your expert report; is that correct?

A. Uh-huh.

Q. "Question: Could you describe, doctor, what you mean in paragraph 4 by your 'best efforts to remove the fetus intact'?

[232]

"Answer: I think I already described that, but what I attempt to do is to grasp the fetal feet with the instrument, and putting gentle traction on that fetal extremity, I try to tease the tissue down so that the fetus comes down feet first through the cervix, the pelvis and the thorax, and I actually get the arms out and just use gentle traction, rather than using the kind of crushing and compressing gestures that one would use to do the disarticulation."

Is that what you said?

A. Yes.

Q. Isn't it true, doctor, that when you were observing the other physician do the abortion that we discussed during the confidential portion of your deposition, isn't it true that you could observe that she was attempting disarticulation because she was using the crushing and compressing gestures that you referred to in what we just read?

A. What she was trying to do was make contact with the fetus. She had not successfully done that. She was exploring the uterus with her forceps to attempt to make contact with the fetus, and to bring it down.

Q. Doctor, it appears that your testimony during the confidential portion of your deposition is inconsistent with what you are saying now. You said during that confidential [233] portion:

> "Question: You told me that you know the physician was not attempting to turn the lie of the fetus. How do you know that they were not trying to do this?
>
> "Answer: Because the physician was disarticulating and attempting disarticulation.
>
> "Question: But she did not succeed in doing that?
>
> "Answer: Correct.
>
> "Question: How do you know that she was attempting disarticulation?
>
> "Answer: Because I could observe her maneuvers with the forceps."

You are telling us now that there are no such gestures.

A. I think the distinction is that she—the difference of what she was doing was introducing the forceps, opening them wide, compressing, and trying to bring down the fetal part so she could start the procedure.

The procedure that we use is generally disarticulation and crushing maneuvers to get the fetus small enough to fit through the aperture.

I was training this person. I knew exactly what her maneuvers were trying to do. She was not reaching up inside the uterus to try to get the fetal feet that were at the top of [234] the uterus and reverse the lie of the uterus.

She was just trying to get—grab onto the fetus and bring it down.

Q. Back to your testimony on page 2 of your deposition, you would agree now that there are crushing and compressing gestures that one would use to do the disarticulation of a fetus?

A. It's basically the same: you close—you open and close the forceps. And if you open and close it on a fetal part and with traction, the whole fetus comes down, that is good. If you open and close it and there is too much traction against the cervix so that it disarticulates, then you get disarticulation.

Q. And you would agree with your prior testimony, I assume, that when you are attempting to remove the fetus intact, you use gentle traction to try to tease the tissue down?

A. It's still the same basic maneuver: You put—you open the forceps. You close it on the fetal part, and you bring it down.

Q. Your testimony in the deposition was truthful?

A. Yes.

Q. Doctor, do you know—do you recollect in the case that we discussed in the confidential portion of your deposition, do you recollect approximately the gestational age of that fetus?

A. I believe it was 23 weeks.

* * * * *

[235]

Q. I think you've testified, doctor, that you sometimes have to compress the fetal skull to complete the removal of the fetus?

A. Correct.

Q. Your purpose in compressing the skull is not necessarily to cause fetal demise?

A. No.

* * * * *

[236]

Q. Using ultrasound reduces the risk of leaving fetal parts inside the uterus?

A. Yes.

Q. The use of ultrasound also reduces the risk of unintentionally injuring the patient with your instruments?

A. Yes.

Q. In approximately what percentage of your second-trimester surgical abortions have you unintentionally injured the patient with an instrument?

A. I can tell you that personally less than 0.1 percent of the time.

Q. This is a remarkably small percentage, correct?

A. Yes, it is.

Q. You also believe that the use of ultrasound decreases the number of times that you have to reach in into the cervix to get a fetal part?

A. It does help you direct the forceps.

Q. It reduces the number of times that you have to reach in with the forceps?

A. It probably does. It is not certain that it does.

Q. Doctor, I think you've testified that in your opinion the intact removal of the fetus in a second-trimester

abortion is safer for the woman than removal by dismemberment?

A. Yes.

Q. Can you identify, doctor, for us which risks of D&E that * * *.

* * * * *

[243]

Q. What percentage of patients accept that offer?

A. All of them.

Q. Do you know whether other Planned Parenthood affiliates offer digoxin before D&E?

A. They do.

Q. How many?

A. I know of one.

Q. Which one is that?

A. Los Angeles.

Q. Do you know of any others?

A. No.

Q. Do you know at what point Planned Parenthood Los Angeles offers an injection of digoxin? At what point of gestational age they offer that?

A. I believe they start at 21 weeks.

Q. In your experience, doctor, does causing fetal demise before starting the removal in a D&E make the removal easier?

A. In my experience it does make it easier.

Q. That is because the fetus is easier to dismemberment?

A. The fetal tissue is softer.

Q. And it is easier to disarticulate?

A. Yes.

Q. And does it also make the head easier to compress?

A. Yes.

Q. In your experience, doctor, digoxin injection is * * *.

* * * * *

[247]

A. Yes.

Q. Are you familiar, doctor, with the procedure known as amniocentesis?

A. Yes.

Q. Now, is it true, doctor, that a physician who has the skill to perform an amniocentesis would also have the skill to perform an injection of digoxin for fetal demise?

A. Yes.

Q. Every OB/GYN learns how to do an amniocentesis?

Q. Correct.

A. Continuing there in Exhibit A-48, second paragraph, second sentence:

> "However, possible complications include, but are not limited to, infection, shock, allergic reaction and even death."

You've seen two cases of infection after a digoxin injection; is that correct?

A. These cases that I assume are related to digoxin injection, yes.

Q. You just assumed that, but it was never shown definitively that the infections were caused by the injection?

A. Correct.

Q. You started using digoxin to cause fetal demise in the year 2000?

A. Correct.

[248]

Q. And you do about 100 per year?

A. That's correct.

Q. And in those two cases that you referred to, no longer term effects occurred in either of those two cases because of the infection?

A. That's correct.

Q. And you don't know of any cases of infection that were actually shown to have been caused by a digoxin injection?

A. Correct.

Q. If any such infection occurred, doctor, emptying the uterus in the course of the abortion would reduce the risk of any long-term effects of an infection?

A. Yes.

Q. The sentence that I just read from Exhibit A-48 lists some other potential complications:

"Shock, allergic reaction and even death."

Now, you have never heard of any occurrence of any of those complications?

A. Correct.

Q. You've never experienced any of them in your practice?

A. Correct.

Q. Doctor, I would like to show you plaintiff's Exhibit 31 in this case. Are you familiar with that book?

A. I am.

MR. SIMPSON: Does the court have a copy of that?

* * * * *

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C 03-4872 PJH

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. AND PLANNED PARENTHOOD GOLDEN GATE, PLAINTIFFS

v.

JOHN ASHCROFT, ATTORNEY GENERAL OF THE UNITED STATES, IN HIS OFFICIAL CAPACITY, DEFENDANT

TRANSCRIPT OF TRIAL PROCEEDINGS
Tuesday, Mar. 30, 2004
Volume 2

BEFORE THE HONORABLE
PHYLLIS J. HAMILTON, JUDGE

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* * * * *

[ELEANOR DREY, M.D. – DIRECT EXAMINATION]

[274]

* * * * *

Q. Dr. Drey, you are a physician at San Francisco General Hospital; isn't that right?

A. Yes.

Q. What is your area of medical specialty?

A. Obstetrics and gynecology.

[275]

Q. Is it all right if I refer to San Francisco General Hospital as SFGH?

A. Yes.

Q. What is your title at SFGH?

A. I am the Medical Director of the Women's Option Center.

Q. Aside from being Medical Director of the Women's Option Center, what other professional activities are you involved in?

A. I'm a generalist obstetrician, gynecologist, so as that, I work as an attendant. So I attend inpatient and outpatient obstetrics and gynecology.

Q. Any other professional activities?

A. I teach residents and medical students and fellows.

Q. And is that through SFGH or some other entity?

A. That's through the UCSF.

Q. I would like to talk to you about the Women's Option Center.

What is the basic mission of the Women's Option Center?

A. It's to provide excellent clinical care and abortion and in contraception. Our mission is also to perform research and abortion care and to train future abortion providers.

Q. And specifically what services does the Women's Option Center provide?

A. We provide options counseling, contraception counseling and provision, abortion counseling and provision, and pregnancy [276] testing.

Q. Generally speaking, to whom does the Women's Option Center provide this kind of care?

A. We have a very mixed population. It's predominantly lower income women, but we also serve high risk medically-complicated patients.

Q. And do you serve patients just from the San Francisco geographic area or is it broader than that?

A. No, actually our patients are drawn from sort of all Northern California and sometimes others states and other countries.

So, we actually serve a large geographic region.

Q. You had mentioned a moment ago that you have a good number of medically complex cases that are referred to you.

Why are medically complex cases referred to the Women's Option Center? Is there anything special about it that specifically—that's specially equips it to handle greater health risks?

A. Well, we are located in a general trauma center and a general hospital. So, as such, we have facilities so that should a woman have a complication in that case, then we would be able to help her.

Q. Now, you testified that you are the Medical Director. What does that job involve?

A. It involves making sure that we provide excellent abortion [277] and contraception care, so overseeing the activities of the clinic primarily.

Q. Do you perform abortions?

A. Yes.

Q. Do you supervise abortions?

A. Yes.

Q. Do you establish protocols for the Women's Option Center?

A. Yes.

Q. Do you supervise any employees at the Women's Option Center?

A. Yes.

Q. Who do you supervise?

A. I am the direct supervisor for the head nurse, the head counselor and one research assistant, but then I generally supervise everyone in my role as Medical Director.

Q. You mentioned teaching earlier, teaching medical students and residents. Does part of that teaching occur at the Women's Option Center?

A. Yes.

Q. Do you do any administrative work in connection with your role?

A. Yes.

Q. Can you describe what you do?

A. I—well, in addition to the functions that I described, I work with the administration of the hospital to ensure that we [278] can continue to provide safe abortion and contraception services.

Q. I would like to turn specifically to the provision of abortions at the Women's Option Center. Does the center provide women with D&E's?

A. Yes.

Q. Up to what gestational age are D&E's performed?

A. We do D&E's until 23 weeks one day or biparietal diameter 56 millimeters.

Q. Now, you say 23 weeks one day is equivalent to biparietal diameter of 56 millimeters. Yesterday, Dr. Sheehan testified that in her practice she does abortions to 24 weeks, which is—which she described as 56 millimeters biparietal—by BPD.

Can you explain the discrepancy between your testimony and Dr. Sheehan's testimony in that regard?

A. Yes. I think those of us who use ultrasound determination of gestational age do so based on the growth charts that are actually programmed into the computer.

So if you had a measurement of a certain number of millimeters based on that growth chart on the ultrasound, you will either get a measurement at 56 millimeters according to one computer, one ultrasound growth chart will be 23 weeks one day another growth chart—sorry. I'm speaking too fast.

THE REPORTER: I'm sorry, 23—

[279]

THE WITNESS: A growth chart that in one ultrasound at a BPD of 56 millimeters is read as 23 weeks one day and another ultrasound will read the same measurement as 24 weeks.

BY MS. MORRIS:

Q. Are you saying that what really matters is the size of the BPD?

A. That ultimately is what we are all concerned about is the size of the fetus and specifically the size of the calvarium.

Q. And why is 56 millimeters the cutoff at the Women's Option Center?

A. That decision was made in reference to considerations of both the technical difficulty of the procedures that we would be performing, but also in regards to limits on viability.

Q. Does the Women's Option Center offer abortion methods other than D&E?

A. We do.

Q. Can you tell me what they are?

A. We also do suction abortions, medical abortions, and induction abortions.

Q. How many physicians provide abortions at the Women's Option Center?

A. We have 16 attending physicians and they supervise a varying number of residents. So those are resident physicians who also provide abortions for first-trimester abortions. They also supervise medical students who provide some of the [280] first-trimester abortions, but not the second-trimester abortions.

Q. How many abortions does the center provide a year on average?

A. Approximately 2,000.

Q. And of those 2,000 what percentage are second-trimester abortions?

A. Slightly over half.

Q. And of the second-trimester abortions, what percentage are performed at 20 weeks or later?

A. Approximately 60 percent.

Q. Why does the Women's Option Center have such a high percentage of patients at 20 weeks or later?

A. It really has to do with the population that we see our responsibility to serve, and that population is poor women. In California—as well as medically-complicated women.

So we, preferentially, women at later gestations who have medical complications are referred to us because we are seen as experts in the provision of late second-trimester abortion.

But in addition to that, we see, as part of our mission, serving the poor women of Northern California and really they have nowhere else to go. There is only one other clinic who can accept all types of medical or the state insurance for these abortions at 20 weeks and above, and they [281] do—they can only accept very few of these because they reimburse very little.

So, essentially, we end up taking care of all of the poor women who need abortions at 20 weeks and above for all of Northern California.

Q. I would like to talk about the Partial-Birth Abortion Ban Act of 2003, which I will call the Act.

Have you read the Act?

A. Yes.

Q. We have a portion of the Act blown up which I will—with permission?

THE COURT: Yes.

BY MS. MORRIS:

Q. Would you please take a moment to read that, again?

Do the physicians at the Women's Option Center perform abortions that fall within the definition of partial-birth abortion in the Act as you read it there?

A. Yes.

Q. Do you yourself perform abortions that fall within this definition?

A. Yes.

Q. Could you please explain what you mean by that?

A. Our—the type of abortions we provide in the second-trimester largely is D&E, but any time you do a D&E abortion, depending on the degree of cervical dilation that you [282] have achieved, then it's possible by grasping fetal parts to deliver the fetus beyond the navel, and then to have to continue the procedure and violate the act.

Q. Do you have any control over when fetal death occurs in the course of that proceeding?

A. Well, I mean you don't have any control over—I mean, what you are really paying attention to is trying to complete the abortion safely. So, what you are mainly trying to do is extract the part safely. So, not exactly.

Q. You are aware, are you not, that there is an injunction in this case that protects the physicians at SFGH from being criminally prosecuted under the Act?

A. Yes.

Q. If that injunction were lifted and the Act went into full effect, what impact would it have on physicians at the Women's Option Center?

A. I think it would have a large impact on our physicians. I think that it would be very difficult for us to continue to provide second-trimester abortions because of this Act.

Q. Can you say more about the effect the Act would have on your ability to perform those abortions?

A. I think that because any kind of—any D&E that we do could end up falling under that definition, the physicians would be concerned that they would be violating this act and, therefore, the physicians with whom I work would no longer feel [283] comfortable performing D&E's.

And, in fact, I already made some changes in the clinic just because of concerns about the Act.

Q. Can you give me some examples of changes that you've made?

A. Well, we usually, we used to really counsel all patients about welcoming someone to come in the procedure with them to serve as a support person, whether that be a family member or parent, a friend, or someone who could come in the room with them.

Because of this act, I was concerned that in the later procedures those people might misinterpret what was happening, and so I no longer encourage the counselors to bring this up.

If a patient requests for a support person to be with them, we don't absolutely restrict it, but we no longer offer it sort of part of our routine counseling like we used to.

I also felt that instead of allowing medical students to observe all of the procedures that we do, I would no longer encourage them to see the later procedures, again, because I was concerned that they might interpret something that we were doing as violating the Act and I didn't want to cause that concern among our staff.

Q. Other than the impacts that you have already talked about, what other impacts would the act have on the Women's Option [284] Center if it were enforced?

A. I don't think we have enough physicians to perform second-trimester abortions, and I think what would end up happening is that poor women would have nowhere to go in Northern California, nor would women with medical complications that might make a D&E more difficult because a huge number, I don't know if all of them, but we get most women as far as I know who have really acute medical or risky surgical issues.

Q. Can you state broadly what impact you think the Act would have on the availability of abortion services in Northern California generally?

A. I think that if you were—well, I was going to say if you were insured you might have somewhere to go, but I think that many providers—in fact, I have had providers call me and say that they no longer are sure whether they should do second-trimester abortions because they don't know if they would be violating this Act.

So, I was going to say that if you had insurance, you might still be able to find a provider. If you don't have insurance or if you have Medi-Cal, you might not be able to find a provider in Northern California who

could provide these services. So I am concerned that women would have nowhere to go to get a second-trimester abortion.

MR. SIMPSON: Your Honor, we must object. I think we're moving into the area of speculation, and we object and [285] ask that the answer be stricken.

THE COURT: I am not going to strike the answer, but I tend to agree that some of it is a bit speculative. I am not going to strike it.

Perhaps you can move on to another area.

MS. MORRIS: Yes, thank you, your Honor.

BY MS. MORRIS:

Q. Just one last topic.

You had mentioned earlier that you get a disproportionate number of women coming to the Women's Option Center who have medical complications or just medically complex cases.

Can you give me some examples of cases like that?

A. We generally get referred women who have had multiple or even one cesarean section in the past, women who are morbidly obese, women who have limited intravenous access, women with placenta previa, women who have severe medical conditions among other complications.

Q. Again, they are referred to you because?

A. Because of our being a trauma hospital, we are able to help them where a free-standing clinic might not feel comfortable to do their abortion because we are seen as the safest place to do abortions for these women.

MS. MORRIS: Thank you. I have no further questions.

[286]

THE COURT: As I recall yesterday, you advised that you were splitting up the examination.

MS. MORRIS: Yes.

THE COURT: So Planned Parenthood counsel wishes to examine Dr. Drey further?

MS. PARKER: Yes, your Honor.

The reason is she is a percipient witness for the City and she's our expert.

[DIRECT EXAMINATION]

BY MS. PARKER:

Q. Good morning, Dr. Drey.

How are you doing?

A. Okay.

Q. I am Beth Parker, attorney for Planned Parenthood.

Dr. Drey, have you also come here prepared to state your opinion as to the safety and efficacy of administering digoxin to cause fetal demise before termination of a second-trimester abortion?

A. Yes.

Q. And before we go into your opinions, I just wanted to ask you a few more background questions.

In addition to serving as the Medical Director of the Women's Options Center, I believe you also indicated that you do some teaching; is that right?

A. Yes, I do.

[287]

Q. And where do you do that teaching?

A. I largely do it at the University of California San Francisco. So that's both at the medical school and at the hospital as one of its sites, but I also teach at other universities.

Q. Do you have a title at UCSF? Can we call University at California San Francisco UCSF?

A. I'm an Assistant Clinical Professor in the Department of Obstetrics, Gynecology, and Reproductive Sciences is my title.

Q. What are your responsibilities as an Assistant Clinical Professor?

A. It is to teach residents, medical students, and fellows as well as to do clinical care and do research.

Q. Do you teach any methods of abortion?

A. I do.

Q. And what are those methods?

A. I teach first-trimester and second-trimester surgical abortions. So, that would be suction abortion in the first-trimester and D&E in the second-trimester.

We also teach induction termination and medical abortion in the first-trimester.

Q. What do you mean by "medical abortion in the first-trimester"?

A. That largely is using the mifepristone, misoprostol and in the first-trimester.

[288]

Q. Do you also do research?

A. Yes.

Q. In what areas?

A. Largely on contraception and abortion.

Q. Do you have any special training that qualifies you to teach in this area and do research in this area?

A. I did a clinical and research fellowship in family planning.

Q. When did you do that?

A. I did that from 2000 to 2002.

Q. Where?

A. At UCSF.

Q. Do you have any ongoing role in that fellowship program?

A. I continue to teach the fellows in that program and assist them with their research.

MS. PARKER: May I approach the witness, your Honor?

THE COURT: Yes.

BY MS. PARKER:

Q. Dr. Drey, I have shown you what has been marked as Exhibit 33.

Do you see that?

A. Yes.

Q. Is that your C.V.?

A. Yes.

Q. Did you prepare it?

[289]

A. Yes.

Q. Is it basically—is it true and correct or accurate?

A. Yes.

THE COURT: Is it basically?

MS. PARKER: Not basically.

BY MS. PARKER:

Q. Is it accurate?

A. It is accurate. But, you know, as time passes, you are supposed to keep it up to date. So I haven't made any minor additions since then.

MS. PARKER: I would like to offer Exhibit 33 into evidence.

MR. SIMPSON: No objection.

THE COURT: Admitted.

THE CLERK: 33 into evidence.

(PLAINTIFF'S EXHIBIT 33 RECEIVED IN EVIDENCE)

BY MS. PARKER:

Q. Dr. Drey, have you served as an expert witness before in a case involving the provision of abortion services?

A. No.

Q. Have you served as an expert witness before?

A. No.

Q. Are you being compensated for providing expert testimony in this case?

[290]

A. No.

MS. PARKER: I would like to move to qualify Dr. Drey as an expert witness in the areas of obstetrics and gynecology in the provision of abortion.

THE COURT: Any objection?

MR. SIMPSON: Your Honor, I am afraid we do have to object to the breadth of that statement. Dr. Drey's expert report was very much limited to the intrauterine injection of digoxin to cause fetal demise.

During her deposition we asked her a long series of questions as to whether she's offering testimony at trial regarding other things. I can read that series to the court.

MS. PARKER: We don't plan to go beyond the digoxin area, but I do think she qualifies as an expert in these areas, which is why I moved her.

THE COURT: I don't know it is necessary on this particular subject to parse out her qualifications so minutely as to limit her to that one area. She clearly has expertise in her role in more than just the area of the use of digoxin.

So, I understand it's broader than most of the offers have been, and perhaps you can narrow it in some way, but I don't—those are two separate issues what she is going to testify on today is separate from the breadth of her qualifications. She is clearly, and I believe you all have stipulated to the basic qualifications of all the medical [291] providers who have medical degrees and some degree of experience in OB/GYN. So she's, in other words, I am going to overrule your objection.

BY MS. PARKER:

Q. Dr. Drey, you have told us that you are prepared to state your expert opinion on the safety and efficacy of the use of digoxin in the second-trimester abortion; is that right?

A. Yes.

Q. What is that opinion?

A. My opinion is that although digoxin is safe in most cases, that that does not necessarily mean that digoxin is safe in every case; that there's some women in whom—and that even though digoxin is safe, that we have not really demonstrated that it is actually effective in making D&E procedures safer.

There are also women in whom digoxin cannot be used because it is contraindicated. Digoxin does not work all the time in order to cause fetal demise. Digoxin technically cannot be administered in some women due to their obesity, and that's all I can think of right now.

Q. Okay.

And now you have provided us with several sort of aspects of that opinion. What are the bases for these opinions about the use of digoxin?

A. The bases are the research studies in which I participated and my clinical experience.

[292]

Q. And what were those research studies?

A. We did a study on the safety of intra-amniotic digoxin and a study on the efficacy of intra-amniotic digoxin.

Q. Would you just describe for us what a safety study is?

A. A safety study, often you will hear talked about as a phase I clinical trial. It's when you have a nonrandomized small group of patients in whom you administer a certain intervention and then you make sure that that intervention is safe. Usually that's a drug.

Q. What is an efficacy study?

A. An efficacy study is where you ideally randomize two groups of—well, usually two groups of subjects to either get the intervention or not to get the intervention, and then you actually see whether the intervention had the intended effect of improving the health or the procedure that you are evaluating.

Q. So you did both a safety and an efficacy study on the use of digoxin?

A. Yes.

Q. When did you do the safety study?

A. The safety study was done in 1998.

Q. When was the efficacy study done?

A. In 1999 to 2000.

Q. Why did you do them?

A. Well, we did them because, as you've heard testify to, [293] digoxin is really used widely in the community of physicians who provide abortions because those physicians—well, they use it for a number of reasons, but I think in part they use it because they believe that the abortion will be safer if they use digoxin.

So, we wanted to study that. That seemed an important question because you don't want to do un-

necessary or potentially dangerous interventions if you don't know that they actually work just based on, you know, clinical experience.

But in order to do an efficacy study, you really ethically need to make sure that the intervention is safe. So before we could do the efficacy study we did a safety study first.

Q. Before we get into the details of the studies I just want to understand your role in the two of them. What was your role in the safety study?

A. My role in the safety study was to help design it, administer it and analyze the results. And then, I was —I wrote up that study.

Q. You were the primary author of the study?

A. Yeah, I was the lead author.

Q. And what about the efficacy study? What was your role in that one?

A. Again, I helped design the study, administer and supervise the study, and helped in the analysis and some of the writing.

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[307]

Q. You indicate you recruited patients for the study. How many did you recruit?

A. We recruited eight.

Q. Why did you select only eight?

A. In designing the study we worked with one of the authors, Dr. Benowitz, who is an expert in design of safety studies.

He is both a pharmacologist and an internal medicine physician. And he felt that eight was an adequate number to determine the safety of intervention.

Q. Did you have any exclusion criteria or did you exclude any types of patients from your safety study?

A. We had a series of excluding criteria.

Q. What were they?

A. Women had to be at least 18 years old.

They had to be able to consent to the study.

They had to have fetal cardiac activity. And then, they would be excluded if they had significant medical illnesses, cardiovascular disease, if they were using cardiac or antihypertensive medications, if they were allergic to digoxin, if they had pregnancy complications, and if they had maternal weight greater than 30 percent above ideal body weight, and if they had poor venous access or abnormal potassium levels.

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[308]

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Q. Hi, Dr. Drey. Before the break, we were talking about the exclusion criteria that you used for the safety study you used on the use of digoxin, and you listed a number of exclusion criteria. I want to ask you a few questions about some of them, if I could.

A. Okay.

Q. One of them, as I recall, you excluded women with significant cardiovascular disease?

A. Yes, we didn't want—since it was a safety study involving a small number of patients, we didn't want to

put—potentially put any women who had cardiovascular disease at any unintended risk.

Q. And why was that? Did it have anything to do with the digoxin, in particular?

A. Yes, because digoxin is a cardiac medication.

Q. I think you also indicated you excluded women with [309] pregnancy complications?

A. We did.

Q. And why was that?

A. Primarily, again, because the study wasn't really looking at how digoxin might be safe in the case of pregnancy complications. And, in particular, the pregnancy complications of having either too much amniotic fluid or too little amniotic fluid might change the results that we would see.

Q. Another exclusion criteria was women who were more than 30 percent over ideal weight?

A. That has to do with the fact that, well, there is more there there. So I think if you have a larger subject you would expect the results potentially to be different based on that.

So if we were trying to see how safe it was for the average person, and given that we were only going to involve eight subjects, we didn't want to change the results by involving women who were very obese.

Q. Was there any other aspect of—for very overly obese women that caused you to exclude them from the study?

A. It's technically difficult to do—somebody take my beeper. Sorry.

It technically can be difficult to do intra-amnoitic injection if someone is morbidly obese.

Q. And why is that?

A. Again, there is more there. I mean, so you are using a [310] needle of a given length, and you have to get through the abdominal wall, and then, in turn, through the uterine wall to get into the place where you need to inject the medicine.

So it is just not easy sometimes if someone has a lot of weight in front.

Q. Were any women actually excluded from your safety study?

A. Yes, we did exclude some subjects.

Q. Do you recall what the reasons were for the actual exclusions?

A. Two subjects were excluded because they had low potassium levels, and one subject was ex—those were the two—those were the two I remember.

Q. The too high potassium levels?

A. Low potassium levels.

Q. Low potassium. And why were they excluded?

A. Because we didn't want to potentially have any arrhythmia associated with the digoxin or affect the results that we would see.

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[320]

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Q. You indicated there were 126 women who were enrolled in the study. And what type of women were they?

A. These were women who were sure that they were going to have an abortion. They were able to consent. They spoke either English or Spanish. And then, we had, again, very similar exclusion criteria from the safety study.

Q. Did they fall within a certain gestational age?

A. Yes, they were all between 20 and 23 weeks, one day.

Q. And you indicated the exclusion criteria were essentially the same as the exclusion criteria for the safety study?

A. Very similar.

Q. Did you end up excluding any women from participating?

A. Some women who were not English or Spanish speakers were excluded. There was a patient who was in prison and therefore unable to consent fairly.

There were patients who had obstetric complications, and then there were women who were excluded for contraindications to digoxin. And one of those women had renal failure and another had uncontrolled hyperthyroidism.

[321]

Q. Do you recall what the pregnancy complication was that caused the exclusion?

A. I believe that they had multiple gestations. That means like twin or triplet gestations.

And then there were women who wanted to be —intended to be randomized, but one woman changed her mind and decided not to have the abortion. And then, another woman, her amniotic—her water broke when we were putting in the dilators.

Q. So how was the study then conducted?

A. So, the subjects, as I said, they received the usual evaluation. Then, they had the dilators placed. They had the digoxin injected intra-amniotically. That was not done under ultrasonic guidance, but correct placement of the needle was assessed, as I described, looking for the amniotic fluid to come up through the needle.

And then, the either 1 milligram of digoxin or the placebo was injected. Then, they also had baseline labs and followup labs. And then, they had the D&E done in the usual way, by either an attending or a resident surgeon.

Q. What were the results of the efficacy study? What were the conclusions that you reached after you conducted the study?

A. The conclusions were that the use of intra-amniotic digoxin did not make the procedure safer by any of the ways that we could assess it.

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[324]

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Q. Could you show us where? Describe for us this table.

A. So, this table is a list of the symptoms or adverse effects that are most commonly associated with digoxin.

And again, if you look at that whole list of symptoms, you know, even though women have them in both groups, if you look at the p value, the only p value that is less than .05, meaning statistically significant, is for vomiting. And in that, about 16 percent of the digoxin group had vomiting, whereas only 3 percent of the placebo group had that symptom.

Q. In your opinion, is that a significant difference between the two groups?

A. Yes, because the p value means that that is essentially 98 percent unlikely to have occurred by just chance alone.

Q. Did your study reach any other conclusions or make any other findings of significance?

A. That the digoxin was not uniformly effective in causing fetal demise within the approximate 24-hour duration.

Q. What was the conclusion about the effectiveness of digoxin causing fetal demise?

A. In 8 percent of the subjects who received digoxin, there was noted to still be a fetal heartbeat at the time of the D&E.

Q. So do you have any overall conclusions about the study, the efficacy study?

[325]

A. Our overall conclusion was that digoxin did not make the D&E—the intra-amniotic digoxin did not make D&E's easier. It didn't make them safer. And it didn't improve the procedure by any objective measure that we could assess.

The only significant difference between the two groups was that the digoxin group had more vomiting.

Q. So did you—do you have any opinions as to whether digoxin has the potential to cause adverse maternal outcomes?

A. I did. I mean, I think that clearly clinical experience has shown us that digoxin is safe overall. But, we know just sort of by medical common sense that if you use a medicine or an intervention often enough, there can be adverse events associated with that medication.

So, I mean, vomiting is unpleasant, but it is not a particularly severe complication for most patients. But, you know, if you use a medication that potentially has effects on cardiac rhythm or even just the amniocentesis injection process itself, eventually you may have a rare but significant risk associated with that.

Q. What type of rare but significant risks could you have from the injection of digoxin?

A. I mean, most dramatically, but I am sure, very clearly unusually would be to cause an arrhythmia that could even lead to the stoppage of the heart, and you wouldn't expect to see that often, and apparently we haven't. Because we would expect [326] people would report that, and that case would make it into the medical literature, and it never has.

So that is good. But, then other problems could be just more commonly the problems like infection that is caused by taking what has been a sterile space, usually sterile space around the fetus and now broaching that and entering—you know, putting something in there that is potentially going to cause an infection.

So that is a risk leading—causing miscarriage before your abortion procedure. Those are some of the risks.

Q. Are there risks associated with the infection that could be caused by, as you said, broaching the otherwise sterile space?

A. I think from obstetrics we are unfortunately all too aware of how serious—I am sorry—infections can be within the uterus. Because essentially we view that space as—we call it "a growth medium," essentially. It is a very rich area for bacteria. Potentially could cause a very serious infection.

So we worry a lot when a woman has an infection in her uterus that it can sort of really develop quite quickly into a serious infection and cause sepsis and potentially even death.

So usually if a woman has a significant infection in her uterus you want to get that infection out of her uterus because it can be so life-threatening.

Q. And you want to avoid it, as well?

[327]

A. And you want to avoid it. You really don't want to potentially take that risk unless you have a good reason to.

Q. And I don't think we have had before a description of what sepsis is. Do you mind describing that to the court?

A. So sepsis is when you have such overwhelming infection, essentially the body in fighting off that infection sort of shuts down. And you end up with low blood pressure and potentially dying from that.

Q. Are there any risks—are the risks with the injection of digoxin any different than the risks that you experience when you do amniocentesis?

A. Our studies don't really look at that specifically, but from just clinical knowledge, the difference ultimately is that in an amniocentesis you are withdrawing fluid. You are just—so that the direction is out. Whereas, in this case you are actually instilling something that has been from the outside in. And though you try to keep the conditions sterile, one would think that you might have more risk of introducing infection going from the outside into the uterus.

Q. And have you seen any situations where the risks were increased as a result of the use of digoxin to cause fetal demise?

A. Well, we had those two cases where we did note that we did something that caused the women to have high digoxin—serum digoxin levels. So that I have seen personally.

[328]

And then, there are cases where women have had serious infections, even lethal infections from amniocentesis. So that is rare.

And I was asked to review a case where a woman received intracardiac potassium chloride to get—to cause fetal demise and where the woman suffered a cardiac arrest where her heart stopped.

Q. Do you know what happened in that case?

A. Oh, she was resuscitated. She had measures to resuscitate her, and she lived.

Q. And then, in addition to the adverse maternal outcomes, you previously talked about vomiting as a side effect?

A. Right.

Q. Is that the most significant side effect that you are aware of?

A. That we saw in our study.

Q. Are you aware of any other side effects from your clinical experience?

A. Just the discomfort of the injection. I haven't seen—personally, I haven't seen other side effects from it.

Q. So after you completed the two safety—

A. I am sorry, except the women miscarrying all over the Bay Area. That was another side effect. Sorry.

Q. So after you completed the safety and efficacy studies, did the practices at the Women Options Center change in terms of [329] their use of digoxin?

A. Yeah, we—I would say that our providers almost immediately very much decreased their use of digoxin because we had been using it in order to make these procedures safer.

But when, by the best study we know how to do, we didn't show that it made the procedures safer, we pretty much abandoned using it before D&E.

Q. And why was it abandoned?

A. Because you don't want to first cause pain in the woman. Second, put her at risk for something that you don't actually think is in her benefit as a patient.

Q. Do you personally offer digoxin now to your patients?

A. Yes.

Q. Do you do it routinely?

A. No, I don't offer it routinely. I will offer it if the woman specifically asks for it, I will go through my understanding of the risks, benefits and alternatives as I would normally consent someone.

And we also do offer it before induction terminations of 22 weeks and above.

Q. Does the Women's Options Center have any protocols for the use of digoxin?

A. We do.

Q. Why do you have those protocols?

A. They provide our doctors with guidelines that they can use [330] to provide intra-amniotic digoxin safely, should they choose to use it.

MS. PARKER: Your Honor, may I approach the witness?

THE COURT: Yes.

BY MS. PARKER:

Q. Dr. Drey, I would like to show you what has previously been marked as Exhibit 35. Have you seen that before?

A. Yes.

Q. And what is it?

A. That is our protocol for the use of intra-amniotic digoxin before D&E.

MS. PARKER: And if I may, your honor, I would like to put it on the ELMO.

THE COURT: All right.

THE WITNESS: I have to say I never noticed this before. Obviously, it is really just the protocol about the intra-amniotic use of digoxin, in general. But it applies to D&E, as well as induction, because that both are mentioned. I have never noticed that before.

BY MS. PARKER:

Q. Does the protocol include the risks of administering digoxin?

A. Yes, it does.

Q. And are those risks essentially the ones that you have been speaking about this morning?

[331]

A. Yes. And the risks are ones that are associated with therapeutic use of digoxin. But we also added the risk of lack of effectiveness. We could include that because of our—the data we had received from our clinical trial.

And then, again, we also included the information about vomiting from our clinical trial.

Q. So could you just read those seven risks for the record?

A. The risks are complications of amniocentesis. And these include: amnionitis, which is infection; amniotic fluid leakage; vaginal bleeding; the onset of spontaneous labor, which I have been discussing as miscarriage; lack of effectiveness. Digoxin was not noted to cause fetal death within 24 hours one out of 10 times; GI symptoms, most frequently nausea and

vomiting in approximately 15 percent; diarrhea or abdominal pain; cardiac arrhythmias, including ventricular premature contractions, ventricular tachycardia; atrioventricular dissociation; sinus bradycardia; AV block and complete heart block; CNS—that is central nervous system—abnormalities; visual disturbances, headache, weakness, apathy and psychosis; and, finally dermatologic reactions, such as maculopapular rash.

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[333]

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Q. Have you had any recent situations where you have encountered this where the situation was deteriorating so rapidly that you didn't have enough time to administer digoxin?

A. Yes. There was a patient who I took care of who was unsure about whether she wanted to continue her pregnancy, but then started having very high blood pressures. And because she was concerned about her other two children and the risks to her health that this pregnancy appeared to be causing, she decided to terminate.

And, in fact, by the time she made that decision her blood pressures were so high that she had to be admitted to the hospital while waiting for her abortion. So we intended to do the abortion the following day. She was diagnosed with a condition called "severe preeclampsia." And it was even worse than the usual severe preeclampsia, because it was affecting her liver and causing her liver to fail.

And it was also causing her to lose her ability to clot. And so we placed laminaria intending to do the abortion

the following day, but actually because her platelets, her clotting factors continued to drop overnight, I was actually [334] called into the hospital in the middle of the night, and we did her D&E at about 2:30 in the morning.

Q. Did you administer digoxin in that case?

A. No.

Q. Do you recall what gestational age she was?

A. I believe she was 22 weeks.

Q. I believe when Ms. Morris was asking you some questions she talked to you about the impact of the Partial-Birth Abortion Ban Act on the Women's Options Center at San Francisco General; is that right?

A. Yes.

Q. And you indicated that you were concerned about the impact on the Center; is that right?

A. Yes.

Q. And what would that impact be, just briefly?

A. I would be concerned that we would no longer be able to provide these services, second-trimester abortions. I mean, by D&E.

Q. Would you consider using digoxin to avoid violating the Act?

A. That would be really a very painful decision for me to make, and I would really have trouble doing that.

Q. Why is that?

A. Because when you usually do a medical intervention on a patient it is for her benefit. So, if I am going to use [335] digoxin, for example, it's—and when I consent her for digoxin, I am saying that I think this

is for her benefit and that the risks are small and that whatever benefit is involved is worth those risks.

I wouldn't even have any idea how to consent a patient if I am giving digoxin for my benefit as a provider. So I don't know what I would say. I wouldn't be saying that this is for her clinical benefit. I would be saying:

> "Well, I need to give you digoxin because otherwise I can't perform your abortion."

So, it is not for her clinical benefit. It is for me. And I just—I would feel very much forced to do something to a patient that wasn't for her. That would just really be awful for me.

Q. And are there situations where even if you used digoxin you would still violate the Act?

A. Well, from our study, if we used digoxin as we felt was safest, which—and the way we felt we could do most reliably, which was intra-amniotic digoxin, I wouldn't have achieved fetal demise within 24 hours 8 percent of the time.

So in that case, even if I gave digoxin to protect myself, in fact, I could still be violating the act in trying to then finish the D&E.

And then, there are situations where, again, if I have used digoxin, but then I felt for clinical reasons I had [336] to proceed with the abortion before I had planned, I would be violating the Act.

And then, there are situations that are emergent where a woman's health may be at risk, but I don't have time to give digoxin, where again I could be violating the Act. And I don't know what I would do in those situations.

Q. Would there also be situations—well, I guess if it was contraindicated you wouldn't be using it.

A. Right. Yes, I mean, in women in who it is contraindicated.

Then, there are the women who I can't get there from here. I mean, it's funny. Looking at this needle, in some ways it looks long. If you are the woman who is having the injection, it looks quite long.

But if you are the doctor doing the injection, sometimes it just doesn't look long enough, because you can't—you know, you can put it up to the hub and still not be able to get where you want to go. So if I can't physically get there, I might not be able to administer digoxin that way.

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[340]

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Q. Now, doctor, causing fetal demise before D&E makes the fetal tissue easier to disarticulate?

A. Yes.

[341]

Q. In your efficacy study, the second study that you testified to in your direct examination, the physicians who performed the D&E's after the injections, whether with digoxin or placebo, those physicians were able to guess whether the patient received the digoxin or a placebo 75 percent of the time?

A. Yes, but you would have expected them to get it right 50 percent of the time. So 75 percent of the time wasn't really as high as we expected.

Those of us who had been using digoxin thought we would always know. And, in fact, we weren't as right as we thought we would be.

Q. And the reason you thought the doctors would always know is that it makes it easier to disarticulate the fetus?

A. The tissue is softer, so it is easier to disarticulate, but that can also make it easier to actually—I am sorry—more difficult to actually complete the abortion.

Q. How is that?

A. Because if the tissue is very soft, instead of being able to draw the fetus down into the lower part of the uterus where it is safer to do the abortion, it may stay up higher in the uterus, and you may have to have more passes with the forceps to draw the fetus out.

So, the downside of having softer tissue is that if it comes apart very easily you have to make more passes, and you have to go up higher in the uterus.

* * * * *

[DREY—CROSS EXAMINATION]

[350] digoxin injection?

A. It is an initial attempt to say that the medication is safe enough that you feel that you can proceed to administer it to a large number of patients. It doesn't mean that even if you do a safety study that the medicine is necessarily universally safe.

Q. Now, your efficacy study, doctor, which you have in Exhibit 30, that involved injection of digoxin into 126 subjects, correct?

A. Yes.

Q. And no complications occurred in any of those patients?

A. There were complications. There were no complications that we specifically associated with the digoxin injection. I mean, there was one major complication.

Q. But, again, it was not associated with the injection?

A. We—you know, there's the science end of it. We can't specifically say it was associated with the digoxin injection. At the same time, I was explaining that my concern with digoxin is that, you know, potentially the tissue is softer so you have to reach up higher in the uterus.

And as you heard earlier when you have to reach up higher in the uterus you are concerned that you might perforate the uterus.

And the one patient who had a uterine perforation had received digoxin. Now, you can't conclude that it was the * * *.

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UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C 03-4872 PJH

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. AND PLANNED PARENTHOOD GOLDEN GATE, PLAINTIFFS

v.

JOHN ASHCROFT, ATTORNEY GENERAL OF THE UNITED STATES, IN HIS OFFICIAL CAPACITY, DEFENDANT

TRANSCRIPT OF PROCEEDINGS
Thursday, Apr. 1, 2004
Volume 3

BEFORE THE HONORABLE
PHYLLIS J. HAMILTON, JUDGE

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[377]

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THE COURT: It's fine. He is testifying under the pseudonym. We will refer to you as Dr. Doe.

THE WITNESS: Thank you.

[DR. DOE—DIRECT EXAMINATION]

BY MS. PARKER:

Q. Good morning, doctor. I am Beth Parker, one of the attorneys for Planned Parenthood.

Have you come to Court today prepared to state your opinion about the Partial-birth Abortion Ban Act and the impact [378] it will have on your practice?

A. Yes.

Q Before we get into that opinion, I would like to ask you some questions about your practice.

You're an OB/GYN; is that correct?

A. Correct.

Q. And do you have a specialty?

A. I have a subspecialty in perinatology or maternal-fetal medicine. They are the same field.

Q. Are you board certified in any field?

A. I am board certified in obstetrics and gynecology and I'm board eligible in maternal-fetal medicine.

Q. What does that mean to be board eligible?

A. I have completed my fellowship. I have passed my written exam for the board, and I am currently collecting cases for—to sit for the oral exam.

Q. And in California do you need to practice a period of time before you can get your certification for OB/GYN, and then for perinatology?

A. Well, not only in California, but throughout the United States. To be board certified you have to practice for a period of time, collect those cases, and then, the exam, oral exam, is based partially on those cases.

I had to do that for general Obstetrics/Gynecology and then, again, for maternal-fetal medicine.

[379]

Q. Where do you currently practice?

A. California Pacific Medical Center.

Q. What position do you hold there?

A. I'm a staff physician and a member of the Maternal-Fetal Medicine Associates.

Q. You recently joined California Pacific Medical Center; is that right?

A. Correct, in October.

Q. Where were you before that?

A. I was at the University of California at San Francisco.

Q. What department were you in at UCSF?

A. Department of Obstetrics, Gynecology and Reproductive Sciences in the Division of Perinatal Medicine.

Q. Did you do a fellowship there?

A. Yes, I did my Maternal-Fetal Medicine Fellowship at UCSF.

Q. Did you also work at the Fetal Treatment Center at UCSF?

MR. QUINLIVAN: Your Honor, I know these are just background questions, but these are leading questions.

THE COURT: But because they are background, I generally permit leading for background.

MR. QUINLIVAN: Very well. Thank you.

THE COURT: And you may do so, as well.

MR. QUINLIVAN: Okay. Very well. Thank you, Your Honor.

THE WITNESS: The Fetal Treatment Center was an [380] entity that was in the conjunction with the Department of Surgery and the Department of Obstetrics and Gynecology.

BY MS. PARKER:

Q. And what does it do? What does it do?

A. The goal of the Fetal Treatment Center is really to provide accurate prenatal diagnosis and the termination, if certain fetal abnormalities might be amenable to procedures in utero that could correct, say, a defect and continue the pregnancy on, and then hope that that would be a better outcome than just repairing the defect after birth.

Q. And what role did you play at the Fetal Treatment Center?

A. I was the primarily the obstetrician who counseled the patients ahead of the procedures, helped to make the diagnosis.

If the patients had therapy were present at the therapies, and then took care of their pregnancies after the therapies.

Q. And did you do that as part of the team?

A. Yes, it was a very big team. It included perinatologists, pediatric aurgeons, neonatologists.

Q. And what is a neonatologist?

A. A Nesonatologist is a pediatrician who has done a fellowship in Neonatology. And that is the care of the premature babies, basically.

There is also anesthesiologists, radiologists and a social worker as part of the team.

Q. How long did you work at the Fetal Treatment Center?

[381]

A. I started doing some work during my fellowship at UCSF, and then I was on staff at UCSF for five years after that. The whole duration I was involved with the Fetal Treatment Center.

Q. Did you also teach at UCSF?

A. Yes.

Q. What did you teach?

A. I taught Clinical Obstetrics and Gynecology to medical students and residents.

Q. Do you currently focus on both on issues of maternal conditions and fetal abnormalities?

A. Yes.

Q. What types of patients do you see currently in your practice?

A. It's a mixture of women who have medical problems going into a pregnant that may impact the pregnancy, as well as conditions that develop during a pregnancy that make it more complicated, or the diagnosis of fetal abnormalities.

Q. And what type of patient care do you provide?

A. I—a few patients of ongoing care during their entire pregnancy. The majority of pregnant—of women as co-managing their consults, and then providing prenatal diagnostic services, which include ultrasound and amniocentesis.

Q. What is amniocentesis?

A. It is a procedure used to try to diagnose a chromosome abnormality in utero. We take a very small needle under [382] ultrasound guidance, place it through the internal abdominal wall into the uterine cavity where the amniotic fluid is; withdraw some amniotic fluid and then remove the needle.

The amniotic fluid then can be tested for a variety of things, particularly in these situations the chromosomes of the fetus.

Q. Do all OB/GYN's regularly perform amniocenteses?

A. All OB/GYN's are trained initially in their residency to do an amniocentesis. The vast majority of general OB/GYN's do not perform amniocenteses regularly in their practice.

In the State of California, the AFP program has kind of de facto made it that only perinatologists perform genetic amniocenteses. The AFP program is a program used to try to detect certain birth defects and karyotype abnormalities.

It is performed from a serum or blood test on the patient. If the results are abnormal she is then referred to a center called a Prenatal Diagnostic Center. Those centers are very closely-regulated in regards to their ultrasound abilities and the outcomes or complications that they have with amniocenteses.

And by this mechanism it is kind of de facto made that only the perinatologists wind up doing genetic amniocentesis in California.

Q. And how many of those prenatal diagnostic centers are there in San Francisco, for example?

[383]

A. I think there are four in San Francisco.

Q. Do you also do what is known as CVS? First, why don't you tell the court what CVS is?

A. CVS or chorionic villus sampling is another type of procedure to diagnose karyotype or chromosome abnormalities.

It is basically a biopsy of the placenta. It is done at an earlier gestational age, and I was not trained to do this procedure in my fellowship, so I do not do it.

Q. Do you perform abortions in the second-trimester?

A. Yes.

Q. Under what circumstances?

A. The circumstances that I provide the abortions are in conditions of maternal disease that could certainly worsen during the course of a pregnancy. Conditions that develop during a pregnancy that puts the maternal health potentially to worsen or in fetal condition—fetal abnormalities.

Q. Okay. So you described three circumstances where you might perform an abortion in the second-trimester. I would like to talk briefly about each of those, if I might.

Could you give us some examples where continuing the pregnancy would compromise the mother's health?

A. There are a lot of medical conditions that can on do it specifically one is something called Eisenmenger's syndrome.

This is a medical condition that is due to usually a congenital heart abnormality that allows communi-

cation of blood from the [384] right side of the heart to the left side of the heart.

The normal situation is that the blood pressure in the pulmonary vasculature is much lower than the blood pressure in the systemic vasculature. You get a little bit of a shunt of blood to the lungs.

That is not a big problem. However, it eventually causes the pulmonary vascular pressure to increase quite a bit.

When you add pregnancy to the mix in these patients that have this disease their systemic pressure drops dramatically during pregnancy. It's a normal phenomena of pregnancy. And you can get a reversal of the shunt of blood, so the blood will then go from the right to the left without going through the lungs.

The patients become—have less and less oxygen in their blood, and this becomes very dangerous. In the object distributing literature, the mortality of this disease in pregnancy is 50 percent. However, it's poorly done retrospective kind of case series.

In the experience of approximately—probably the last eight patients that we took care of at UCSF with this condition all of the women died postpartum.

THE COURT: What was the condition again?

THE WITNESS: Eisenmenger's syndrome.

BY MS. PARKER:

Q. And what is "postpartum"?

A. After delivery.

[385]

Q. Could you give us some examples of some of the fetal abnormalities that you see complicate pregnancy or might suggest an abortion in the second-trimester?

A. The most common I see are karyotype or chromosome abnormalities. Those could be Trisomy 21, which is Down's Syndrome. Trisomy 21. Trisomy 18 or Trisomy 13. These are the most common chromosome abnormalities that I see.

There are other structural fetal abnormalities, such as congenital heart disease, diaphragmatic hernia or spina bifida.

Q. And how late do you perform abortions?

A. I perform abortions to an equivalent of 23.1 weeks gestational age.

Q. How do you measure that?

A. I measure that by the biparietal diameter, which is an ultrasound measurement of the fetal head. And my cutoff is 56 millimeters.

Q. Why do you not go beyond 23.1 weeks gestational age?

A. In my training when I learned the procedures I wasn't trained to go beyond this size of a fetal head.

Q. What methods of abortion do you use in this second-trimester?

A. I use dilation and evacuation and induction of labor.

Q. And what is the breakdown of those two types, approximately?

[386]

A. Approximately 75 percent D&E and 25 percent induction.

MS. PARKER: Your Honor, may I approach the witness?

THE COURT: Yes.

BY MS. PARKER:

Q. Dr. Doe, I have shown you what has been marked as Exhibit 32. Do you see that?

A. Yes.

Q. Is that your curriculum vitae?

A. Yes.

Q. Is the information in it current?

A. Yes.

Q. Is it true and correct?

A. Yes.

MS. PARKER: Your Honor, I would like to offer 32 into evidence.

THE COURT: All right. Any objection?

MR. QUINLIVAN: No objection, your Honor. I—well—

THE COURT: The copy I have has not been redacted.

MS. PARKER: Has not been redacted?

THE COURT: No.

MR. QUINLIVAN: That was my concern. I did not know: Was this a redacted version or not?

MS. PARKER: Yes. We will substitute with a redacted version. I apologize. I thought we had.

[387]

THE COURT: Actually, I am not even sure the redacted version gives enough information that it is even—you will need to admit it into evidence. You all have stipulated to his basic qualifications. I don't see that you need to have—

MS. PARKER: The C.V. into evidence?

THE COURT: —The C.V. into evidence.

MS. PARKER: Then, we won't do that.

Then, we will move to qualify Dr. Doe as an expert witness in the areas of obstetrics and gynecology, perinatology and abortion practice and procedure.

THE COURT: Any objection?

MR. QUINLIVAN: No objection, your Honor.

THE COURT: It will be accepted.

BY MS. PARKER:

Q. Dr. Doe, have you ever testified as an expert before in a case involving abortion?

A. No.

Q. Are you being compensated for providing expert testimony in this case?

A. No.

Q. Do you have any affiliation with Planned Parenthood?

A. No.

Q. So I want to go back and talk a little bit about some of the conditions that you treat. Do your patients ever choose to [388] end their pregnancy due to a maternal health condition?

A. Yes, they do.

Q. And does this sometimes arise when medical conditions—with medical conditions that a woman had before becoming pregnant?

A. Yes.

Q. I know you gave us an example of Eisenmenger's syndrome. Are there other examples you could provide?

A. Other examples would be primary pulmonary hypertension, again, can lead to some of the same problems where the pulmonary vasculature has very high blood pressure leading to low oxygen in the blood and high risk of mortality.

Another condition would be type I diabetes with multiple vascular complications. And what I mean by that is that their kidneys are affected and don't have normal kidney function, or they have kidney—they won't have normal kidney function, or impaired vision, because the diabetes has affected the blood vessels that supply blood to the eyes.

Q. And are there any others that you can think of, conditions that a woman has before she becomes pregnant?

A. None right now.

Q. Okay. And would the patient know she has these diseases before she became pregnant?

A. The patient may know this or may not know that she has these diseases, depending on her access to care and how often [389] she's seen a physician and whether the physician has necessarily picked up on these problems or not.

Q. If she chose to terminate the pregnancy, when in the pregnancy would she make that decision, typically?

A. Well, I mean, ideally it would be as soon as possible, because the ongoing process could continue to effect the disease. But often these decisions aren't—or diseases and referrals aren't made until the second-trimester.

Q. Are patients sometimes forced to—or are patients sometimes choose to end a pregnancy due to a medical condition that is created by the pregnancy?

A. Yes.

Q. And could you give us some examples of those?

A. It would be rare, however. Severe preeclampsia is something that could present in the second-trimester. Then cervical incompetence, the premature rupture of membranes, to other conditions.

Q. What is preeclampsia?

A. Preeclampsia is a disease of pregnancy that is probably due to a placental abnormality. It manifests itself by hypertension in the patient, as well as protein in the urine, and can then effect all organ systems within the body.

Q. And is it fairly serious, preeclampsia?

A. Yes, it is very serious. And pretty much prenatal care was developed to diagnose preeclampsia. The whole reason that—[390] if you know at many prenatal

visits you have your blood pressure taken and you give a urine sample it is all to be able to pick up preeclampsia.

Q. What happens if preeclampsia is not diagnosed?

A. If preeclampsia is not diagnosed it could lead to kidney failure, rupture of the liver, a seizure and ultimately death.

Q. And you indicated that preeclampsia sometimes arises in the second-trimester?

A. Correct.

Q. And when that occurs what choices does the pregnant woman face?

A. It really depends at what point in the second-trimester, but if it is certainly before viability, it is unlikely and unsafe to try to continue the pregnancy to viability, and really the only choice is termination of the pregnancy.

Q. You indicated another example was cervical incompetence of a condition that is created by the pregnancy itself. What is cervical incompetence?

A. The cervical incompetence is that the cervix is unable to kind of hold and maintain the pregnancy, per se. The cervix is structurally weaker, for some reason, and will just kind of, without pain or contractions, dilate and open up. And usually these can lead to extremely premature delivery, or could lead to a subsequent other problem was premature rupture of the membranes.

[391]

Q. And what happens if cervical incompetence occurs in the second-trimester? What choices does the pregnant woman face?

A. The choices involve kind of what we call expectant management, kind of putting the person to bed and hoping that the pregnancy doesn't kind of proceed to go on to deliver. But it is high risk of delivering a fetus that's extremely premature.

Another option is something called a "rescue cerclage" in which we try to put a stitch into the cervix and close it up.

In the situation where the cervix is already dilated from cervical incompetence and doing this after the fact rather than as a prophylactic measure, the results are pretty dismal with the rescue cerclage.

And then, the final choice would be a termination of pregnancy.

Q. Are their risk factors for women who have cervical incompetence?

A. Yes. They include women whose mothers took DES. It is a medication that was a hope to try to decrease the chance of miscarriage. However, in the female offspring of women who took this medication, they are at higher risk for a number of gynecologic complications: cervical incompetence is one of those.

Other known risk factors are greater than three [392] second-trimester terminations and certain collagen vascular diseases could put the patient at risk for cervical incompetence.

Q. And are there women who have no risk factors who develop cervical incompetence?

A. Yes.

Q. Is that a majority of the cases or not?

MR. QUINLIVAN: Objection, leading.

THE COURT: Overruled.

THE WITNESS: I would say most patients you can identify some risk factor, but there is a considerable number of patients that have no risk factors whatsoever.

BY MS. PARKER:

Q. And I think the third example you gave us of a health condition that can develop during pregnancy that might cause a woman to choose to terminate the pregnancy was premature rupture of the membranes; is that right?

A. Yes.

Q. And could you describe for us what that is?

A. That happens when the amniotic membranes have a hole rupture in them, and the amniotic fluid leaks out. This puts the patient at considerable risk for infection and potentially very severe infection. Results in trying to maintain the pregnancy at this point are kind of uniformly dismal. The usual recommendation is for both maternal health and for the [393] poor potential outcomes for the fetus is to terminate the pregnancy.

Q. What is the general time frame that these three conditions that you've talked about manifest themselves?

A. All in the second-trimester.

Q. And if a pregnancy termination were indicated for their conditions, when would that pregnancy-termination occur?

A. In the second-trimester.

Q. Do your patients ever choose to end their pregnancy due to a fetal anomaly?

A. Yes.

Q. Can you give us some examples of those?

A. I would say the first example is a category of chromosome abnormalities, and these include trisomy 21, also known as Down's syndrome; Trisomy 18; Trisomy 13. However, there are a number of other fetal chromosome abnormalities that are less common that are sometimes diagnosed.

Q. Are any of these lethal?

A. Yes, Trisomy 18 and Trisomy 13 are considered lethal.

Q. What is Trisomy 18? How does that show itself?

A. Trisomy 18 is a condition where there is three copies of chromosome number 18. It is usually—well, not always, but often can be diagnosed prenatally by kind of a multitude of fetal abnormalities that are—that can be seen, structural abnormalities that can be seen on ultrasound, often prompting [394] amniocentesis.

Additionally, the AFP test helps screen for Trisomy 18, so you can identify some women who might be at higher risk for this, and then warrant the amniocentesis.

Q. And how does—what about Trisomy 13?

A. Trisomy 13, there's not a blood test that helps screen for it, but usually the fetus has structural abnormalities that are consistent with the condition.

Q. You indicated there were additional fetal abnormalities in addition to the chromosomal ones you just mentioned?

A. Yes. Those can be identified, I guess, as structural abnormalities. Those include congenital heart disease. Now, some aspects of congenital heart disease are very mild and can be very normal, while others are very severe and may die or have a very, very difficult life with multiple hospitalizations and sick their entire life.

A condition called "congenital diaphragmatic hernia" is a situation where the diaphragm doesn't form appropriately, and liver and intestines can be up into the chest. This does not allow the lungs to develop appropriately, and it is very high, high likelihood of death at delivery. Or if the infants do survive, they have multiple, multiple medical problems and require multiple surgeries, long stays in hospitalization, and baseline intelligence is significantly decreased.

Q. In addition to congenital heart disease and congenital [395] diaphragmatic hernia, are there any other structural abnormalities?

A. One of the other or two most common ones are neural tube defects, which could be—anencephaly is on one spectrum is where a brain doesn't appropriately develop. And there is development of the cranium up to the level of the eyes, with nothing beyond that.

There is a brain stem, but no more brain tissue and they have no higher functioning whatsoever. As well as another type of neural tube defect is something called "spina bifida" where there is an opening or splaying of the spine that allows the exposure of the spinal cord. And often the patients are paralyzed from that level downwards.

Q. Are any of these structural anomalies lethal or potentially fatal to the fetus?

A. Some of them can be lethal, yes, and many of them are associated with decreased life expectancy for the infant, as well as major difficulties kind of growing up and hospitalizations, multiple infections, other such things.

Q. So in addition to the Trisomies, and then the structural anomalies, are there any other type of fetal anomalies?

A. There are other fetal abnormalities that I guess we can coin kind of as genetic, that there is a particular single gene that is missing.

Examples of these are something called Tay-Sachs [396] Disease or Canavan's Disease.

Another example is something called Spinal Muscular Atrophy. Many of these are degenerative, neurologic conditions. The fetus is born alive, however eventually the infants stops making its milestones, and then kind of deteriorates and ultimately dies.

Q. And you indicated these were genetic diseases. Are they seen in certain population groups?

A. They are often in some population groups that have higher risks of autosomal recessive diseases. And this is where both parents are carriers for a particular gene and you have to be missing both copies of the gene for the disease to manifest.

A population such as the Ashkenazi Jews are one that is at particularly higher risk for Tay-Sachs and Canavan's Disease.

French Canadians are at higher risk for Tay-Sachs, as well. There are genes that effect hemoglobin, which is the blood-carrying molecules. And in populations, Mediterranean and African populations, as well as

Asian populations, they are at higher risk to have Thalassemia.

Q. In what general time frame of pregnancy are abortions for fetal conditions typically performed?

A. They are typically performed in the second-trimester.

Q. Why is that?

A. Because diagnosis isn't made until the second-trimester.

[397]

Q. How is diagnosis done for these various fetal abnormalities?

A. The chromosome abnormalities are done by amniocentesis or chorionic villus sampling.

The structural abnormalities are diagnosed by ultrasound. And that ultrasound really needs to be performed in the second-trimester because it is just too difficult to see some of these structures at an earlier gestational age.

Q. So when you are doing the ultrasound diagnosis for the structural abnormality, approximately when does that ultrasound happen?

A. Usually between 18 and 20 weeks gestation.

Q. And when you use ultrasound, can you do a complete diagnosis of the structural abnormality?

A. Sometimes you can. Sometimes you can't.

Q. If you can't, do you need to do any additional diagnosis?

A. Sometimes amniocentesis is done. There are conditions sometimes that we know that this is a very

severe condition, but we don't have the exact diagnosis. Without having the exact diagnosis we can't give a recurrence risk. And we might recommend a fetal autopsy be done.

Q. Let's talk for a moment about the amniocentesis. You indicated that was another diagnostic tool that you use to determine a chromosomal anomaly; is that right?

A. Yes.

[398]

Q. And when is amniocentesis typically done?

A. Typically done between 15 and 20 weeks gestation.

Q. And how long does it take to get the results?

A. Approximately seven to 14 days.

Q. And does amniocentesis present any special risks to the pregnant woman?

A. Yeah. The risks of amniocentesis as kind of with any procedure are bleeding and infection, and in this situation, also, kind of loss of the pregnancy.

Q. Do you typically do amniocentesis on every pregnant woman?

A. No . You could argue maybe be offered for every pregnant woman, but it is typically offered to women that appear to be at higher risk for these problems. It's been in the United States kind of age 35 and beyond.

But if we also diagnose an abnormality in ultrasound or their blood AFP test is abnormal, the patient is referred to genetic counseling and talking about the risks of having one of these abnormalities and

the risks of the procedures. And then, they decide whether they want to proceed with the procedure.

Q. Are there any fetal anomalies of the ones you have talked about or others that will actually increase the risks of pregnancy?

A. There is one particular chromosome abnormality that could increase the risk of preeclampsia at a very early gestational age, and this is called Triploidy.

[399]

Q. And what happens with Triploidy? Why don't you first tell us what Triploidy is?

A. Triploidy is that you have a karyotype of 69xxy. So you have an extra kind of path to the karyotype, so it is way too many. You have placenta and fetal abnormalities, and you have very large placenta. And it appears to be, for some reason we don't understand, a much higher risk of development of preeclampsia, and usually development of preeclampsia in the second-trimester.

Q. And what—when that happens, what is the general recommended course?

A. Termination of pregnancy.

Q. And why is that?

A. Because the fetus isn't normal, for one. And for number two, that the preeclampsia will proceed and the potential complications of the preeclampsia are very severe, as I had mentioned earlier.

Q. Now, you indicated that you currently use two methods of abortion in the second-trimester; is that right?

A. Yes.

Q. I think the first one you mentioned was a D&E?

A. Correct.

Q. Dilation and evacuation. What is your goal in performing a D&E abortion?

A. My goal is to do the procedure as safely as I can for the [400] woman.

Q. And how do you achieve that?

A. I achieve that by trying to make as few passes into the uterus.

Q. Why is that?

A. Because we know that the major risks of the procedure are associated—are infection, bleeding, uterine perforation.

And by making a pass with these instruments into the uterus that is when you are at risk for having these complications.

The more times you have to go into the uterus, the higher chance there is of a complication.

Q. What do you base that opinion on, that you want to do it as few passes as possible?

A. Common sense, experience, and I guess extrapolation from other studies that we know of, a certain procedure causes the potential risk of something. The more you do that, the higher the chance of that complication.

Q. Can you describe for us how you perform a D&E procedure?

And actually, before you do that, would it be helpful if you used a picture of a—

A. Yes.

Q. —of the anatomy?

A. Yes, I think so.

MS. PARKER: May I approach the witness, Your Honor?

THE COURT: Yes.

[401]

THE WITNESS: First of all, we will counsel the patient regarding her options and what she wants to do with the procedure. We talk about the risk and benefits, and I also talk about the risk and benefits of induction of labor, depending on what the exact indication for the pregnancy termination is.

Usually a day prior to the procedure, then, if she wishes to proceed, we do a placement of laminaria. And we put a speculum within the vagina which opens up and allows us to visualize the cervix, which is right here (indicating).

We place the laminaria, which are kind of osmotic dilators, into the cervix after washing it off with an iodine soap and putting some local anesthesia into the cervix.

The following day the patient would come, in my situation, to the hospital. She would meet the pre-operative nurse. She would meet the anesthesiologist. She would have an IV started. She would have some blood work drawn.

I would meet again with the patient to make sure she didn't have any questions prior to the procedure. And then, she would be taken to the operating room.

BY MS. PARKER:

Q. Before we go there, I have couple of questions about the laminaria. How many, typically, do you use, laminaria?

A. It depends on the gestational age of the fetus and on whether or not the patient's had a vaginal delivery before.

[402]

Q. And what is the factors with gestation age? Is it more or less?

A. The bigger the gestational age, the older the fetus is, the bigger the fetus is going to be, the more dilatation I am going to need. That means the more Laminaria I am going to put in.

Q. Do you ever use a second set of laminaria?

A. Sometimes I use a second set of laminaria, depending again on gestational age and how many I am able to place the first time.

Q. Can you predict the amount of dilation you are going to get from the laminaria?

A. You can have a very rough prediction, but most of the time I can't predict that well how much dilatation I am going to have.

I think I have—I am going to know enough to complete the procedure. Whether it is very dilated or just enough to do the procedure, I think is very, very hard for me to be able to predict.

Q. So you indicated the woman comes back 24 hours later. Does she stay in the hospital for the first 24-hour period?

A. No, she doesn't. She has the laminaria placed, and then she is able to go home.

Q. So you indicated she comes back on the second day, and then what happens?

A. She comes back the second day. Again, she's met the nurse, [403] the anesthesiologist, asked any other questions that she has.

She is then—we make sure she is the correct patient. She is then taken to the operating room, and she's given a general anesthetic.

Next, the patient is placed in stirrups, and then a —her perineum, part on the outside of the vagina and legs are prepped with a betadine solution.

Next, the speculum is placed again within the vagina. I remove the laminaria that have been there previously and make sure the dilatation is adequate for the procedure.

I again prep both the vagina and cervix with this iodine soap.

Next, I administer a medication called vasopressin, which is a vasoconstricting agent that will help decrease blood loss, and I give this injection into the cervix.

I use ultrasound when I do the procedure, so I have continuous ultrasound watching while I do the procedure because I think it decreases the risk of uterine perforation. And that is how I was trained.

Next, a suction cannula is placed within the cervix up into the fundus of the uterus, and then there is kind of a turn of the wrist and the amniotic fluid is then aspirated.

Q. What do you mean by "aspirated"?

A. The cannula is attached to a suction machine. It is kind of—the amniotic fluid is then sucked out.

[404]

Next, I proceed with using a forceps instrument called a Bierer forceps, usually, to extract the fetal tissue.

Upon completion of the procedure, that I make sure that all fetal parts are present, and I make sure that the placenta is removed.

I watch to see if there is any continued bleeding, either from the cervix or above the cervix from the uterus. Once I am sure that there is no further bleeding, an instrument, which I forgot to mention, that is put on the anterior of the cervix, called a "tenaculum" to kind of help hold it in place, I remove that. And I remove the speculum. The patient is woken up and taken to the recovery room.

Q. Do you ever use misoprostol, and what is misoprostol?

A. Misoprostol is a medication that can be used to induce labor.

Q. Do you ever use it during the D&E procedure?

A. I sometimes use misoprostol in the D&E procedure if I have a very advanced gestational age or a cervix that I couldn't get many laminaria in. I sometimes have the patient come the day of the procedure a little bit earlier, and we give misoprostol prior to kind of soften the cervix and make it dilate a little bit more.

Sometimes, additionally, which I didn't mention, sometimes the cervix isn't quite dilated as much as I need, and we have instruments to help dilate that. And

occasionally I [405] have to do that. And when, in my experience, when I have given misoprostol ahead of time, that dilatation appears to be a little bit easier if I need to do it.

Q. Do some women deliver the fetus partially as a result of the misoprostol?

A. Yes, they can.

Q. And when that happens, could the fetus be outside the uterus past the navel of the fetus?

A. Outside the uterus, yes, and potentially even outside the vagina.

Q. And could it be alive?

A. Yes.

Q. And when that happens, how do you complete the procedure?

A. Usually, if the fetus is coming out, the easiest method is to try to do how we would do a breech. It often comes out in a breech presentation. And, again, that is feet first, head second. We do the similar maneuvers that we would do to do a breech delivery.

However, sometimes the cervix is not dilated enough to allow the calvarium to pass.

Q. And what do you then do?

A. I would separate the calvarium from the body.

Q. When you perform the evacuation in the typical D&E, do you ever need to convert the lie of the fetus or the direction of the fetus?

[406]

A. Sometimes. Sometimes the fetus is, again, what we would call vertex or cephalic. And that is when the head is presenting at the cervix.

The head is the difficult—the most difficult portion to deliver in these procedures, and occasionally I will see if I can deliver the cranium initially. Often that doesn't work, and I would need to reach in a little bit higher up with the forceps, grasp the lower extremity and pull down, and that kind of converts the presentation to a breech presentation.

Q. When you are doing your regular procedure, does it ever happen that you bring out the fetus intact or partially intact up to the head?

A. Yes, sometimes it does.

Q. Approximately how many times does it happen in your procedures?

A. Maybe 15 to 20 percent.

Q. And when this happens, do you consider it to be a different procedure from an abortion than one which is disarticulated before that point?

A. I don't think it is different, and I feel fortunate when it happens in some ways, because I think that I will then have less passes into the uterus, and I think less chance for injury or infection.

Q. Before beginning the D&E procedure, can you predict if that is going to happen or not?

[407]

A. I don't think you can predict. There have been plenty of cases where I think I am going to be able to get out the fetus without disarticulating it, and I

cannot. But there have been cases where I think I am going to have a—it is going to be a difficult one, a hard one, and I am able to deliver the fetus intact.

Q. And is there anything that determines whether it will be able to come out intact or partially intact?

A. I mean, I think ultimate cervical dilatation does, but then, even beyond that sometimes I think it is therefore unpredictable.

Q. In your opinion, is it safer if the fetus emerges intact or partially intact?

A. In my opinion, it is safer if it emerges partially or as intact as possible. I think it is safer.

Q. And why is that?

A. Because then I have to make fewer passes into the uterus with my instruments, and that would decrease chances of infection, chances of uterine perforation or cervical laceration.

Q. In your opinion, are there any special health risks if the fetus emerges intact or partially intact?

A. No.

Q. How long does the evacuation part of the D&E procedure take when you do it?

[408]

A. Usually 15 to 30 minutes.

Q. Do you know when in the course of that procedure the fetus dies?

A. No.

Q. Do you ever pay attention to that?

A. No.

Q. Do you ever use digoxin to cause fetal demise?

A. No.

Q. Why not?

A. In reading the studies, I am not convinced that it has any particular benefit. And it potentially has some risks. And I try not to do things, medical procedures, that have very little benefit and have some risk associated with them.

Q. Now, you also indicated you do induction abortions. That's the other method of abortion you use? Could you—under what circumstances would you do an induction or recommend an induction?

A. I would recommend an induction in situations where the diagnosis of the fetal abnormality—that is often what the indication would be for the procedure—is unclear. And, again, without knowing the diagnosis, it is very hard to give a recurrence risk to these couples.

If we have an intact fetus where an autopsy can be performed we have a better chance of arriving at what the diagnosis is, and then a better chance of having the recurrence [409] risk.

But if we have kind of an unclear diagnosis I usually recommend induction of labor, instead.

Q. Can you describe for us the procedure you use to do an induction abortion?

A. Again, I would thoroughly counsel the patient regarding the risks and benefits of both procedures. If she elected to proceed with induction of labor, she would come into the hospital, have an IV started, and then have misoprostol tablets placed within her vagina,

usually in what is called the posterior fornix, or right behind the cervix, back here (indicating).

Q. Is that typically done in the hospital?

A. Yes.

Q. And then, what happens after the misoprostol is inserted?

A. It takes some time to kind of work to soften the cervix, maybe get it to dilate a little bit and basically induce labor.

Probably in the bulk of the patients it takes 24 hours duration before delivery, but it can be as long as 48 hours.

Approximately 90 some percent of patients will delivery within 48 hours after initiating this process.

Q. And when during in induction does fetal demise occur; do you know?

A. I don't know. It really depends on gestational age, and sometimes the fetus is born alive.

[410]

Q. Are there ever circumstances where an induction has to be converted into a D&E procedure?

A. Yes. I have a particular experience in that if the induction fails, it just doesn't work. If we are going on kind of 48, 72 hours and still no delivery, if there is adequate cervical dilatation it can be converted to a D&E.

Sometimes bleeding could be significant enough that you could convert to a D&E to try to slow the amount of blood loss that is occurring.

Q. And are there any circumstances for which induction is contraindicated?

A. Yes. There are some conditions that induction would be contraindicated. One is placenta previa. That is where the placenta is implanted over the cervix and kind of covering the cervix. The fetus would be up higher. This—the fetus would have to deliver through the placenta, and it causes a tremendous amount of bleeding where the placenta previa is.

So an induction of labor is contraindicated in that situation.

There are uterine conditions where an induction of labor would be contraindicated. That could be previous uterine surgery, something called a hysterotomy, or previous cesarean section. There are different types of cesarean sections.

Q. Why don't we stop there for a moment, because I think you have talked about a couple of conditions we haven't previously [411] mentioned.

What is a hysterotomy?

A. A hysterotomy is an incision through the uterine wall into the uterine to open up the—expose the uterine cavity.

Q. What about a cesarean section; what is that?

A. A cesarean section is a hysterotomy, but it is done to deliver a viable fetus. Now, a cesarean section, there are two types, really, of cesarean sections. It can be what is commonly known and most women wind up having something called a "low transverse cesarean section."

Maybe if I have the other diagram it might help.

MS. PARKER: May I get that, your honor?

THE COURT: Yes.

THE WITNESS: So most women at term would require having a cesarean section. The cesarean incision is made in this kind of lower uterine segment. And when the uterus is pregnant, and the term fetus here is—the uterus is stretched and much, much bigger.

This lower segment stretches out and is very, very thin. It doesn't have a lot of muscle within it that involves kind of contracted portions kind of labor. So if you make a transverse incision down here (indicating), the risk in subsequent pregnancies of that rupturing or opening up is very, very small.

It is approximately half a percent. An uterine [412] rupture can be a catastrophic event for the fetus and for the mother.

At earlier gestational ages, this lower uterine segment may not be developed, and it is not wide enough to do a transverse incision here.

The uterine blood vessels are kind of right here and kind of coming in here and have a tremendous amount of blood going to the uterus in pregnancy.

And if you get out into those you can have quite a bad hemorrhage occur, and potentially a woman can die from that.

We often have to make what we call a classical uterine incision. And this is a vertical incision made up here (indicating) or even up and around what we call "the fundus," or top of the uterus.

This sort of incision is going through a thicker area and a lot of muscle involved in contracting. It has

a bigger blood loss, a little bit harder repair to do. It has a much—in subsequent pregnancies has many greater risk factors than if a woman had a low transverse cesarean section.

Using these misoprostol as such a strong agent to promote very, very strong uterine contractions with an induction, the risk of rupturing that scar is significant.

BY MS. PARKER:

Q. That is why induction is contraindicated where there has [413] been a prior cesarean section or hysterotomy?

A. Correct.

Q. Are there other contraindications for induction in addition to those two?

A. There are, again, some medical indications that theoretically misoprostol would be contraindicated.

It goes back to that pulmonary hypertension or Eisenmenger's syndrome, that the agents that—and misoprostol being the primary one now that causes uterine contractions, also can cause contraction of the muscle within the blood vessels in the pulmonary tree. It can worsen the conditions that we were talking about before.

Q. So that's one example where the medication would make induction contraindicated?

A. Correct.

Q. Are there other examples?

A. Asthma has a relative contraindication. You can get the spasm of the air—the bronchial tree. And

constriction of that is what asthma is. And it could worsen asthma, potentially.

Q. And what about cardiac conditions, ever contraincidated--is induction ever contraindicated for cardiac conditions?

A. Yes. Potentially with the pulmonary hypertension and with the Eisenmenger's syndrome could be. For the same reason, again, of the constriction of the pulmonary vasculature.

[414]

Q. So in addition to the contraindications, are there any just risks of an induction abortion?

A. Certainly there are risks of induction abortion. And the biggest ones are infection, bleeding, and a retained placenta where the placenta doesn't deliver after the fetus delivers. And you subsequently need a surgical procedure, like a D&E, to go in and remove the placental tissue.

Q. And do you have an opinion about the safety of inductions?

A. In my experience, I have had more complications with inductions of labor rather than D&E's. Both have been safe, but I have had more bleeding complications and having an induction kind of fail or placenta not come out, had to take them to the OR. I have basically done both procedures on the patient then.

Q. And could you ever do a hysterotomy if an induction was contraindicated?

A. You could do a hysterotomy if an induction was contraindicated, but hysterotomies have the biggest risk of any of the procedures to end the pregnancy.

And, again, this would be typical to what a classical cesarean section is where you make your incision through the thick portions and muscular portions of the uterus. And not only does it have a much greater blood loss potential and it's an abdominal surgery which has risks of potentially injuring other organs at the time, subsequent pregnancies are greatly at much higher risk [415] than if the patient had a D&E.

Q. And why is that? What are those long term risks?

A. Those long term risks is when you have had a hysterotomy and this big incision coming down here (indicating), the biggest risk is probably uterine rupture in a subsequent pregnancy. And that can be anywhere from about ten to twelve percent risk of a uterine rupture.

Additionally, in women incisions such as that, the uterus really doesn't heal completely normal. And if a placenta implants upon that area, you can get something called a "placenta accreta."

And a placenta accreta is a condition where the placenta grows into the myometrium, or the muscle of the uterus. And it can sometimes become an increta, in which it goes all the way through the muscle. Or sometimes even something called a percreta, which it grows outside of the uterus, and potentially into the fallopian tube, into the ovary, into the bladder, into the vagina, and all sorts of things. Particularly, particularly morbid condition, and the treatment is a hysterectomy at the time of the subsequent delivery.

Q. And what is a hysterectomy?

A. A hysterectomy is where the uterus is removed.

Q. So when you are meeting with your patients and discussing the different abortion methods that they have an option for, do [416] you talk to them about the relative safety of the methods?

A. Yes. I talk to them about the relative safety of the methods, the potential benefits to the methods. And sometimes I won't have much of an opinion of which way they should go. Sometimes I will steer them a little bit. And mainly, in whether or not we need an autopsy or not to give them recurrence information.

Q. And what do you tell them about the risks of the different types?

A. I say that they are close to being essentially equal, however I have had more bleeding complications and needing to go back to the OR to do—to remove a retained placenta with induction.

Q. Now, I think I asked you a few minutes ago—I don't know if you want to sit down. We will move into a different topic.

I asked you whether you ever used digoxin to cause fetal demise when you were doing a second-trimester procedure. You indicated you do not?

A. Correct. I do not use digoxin.

Q. Do you ever use KCl, potassium chloride, to cause fetal demise?

A. I can think of one or two cases where I have had to use potassium chloride to terminate the fetus prior to a procedure.

Q. But that is not generally part of your practice?

A. No.

[417]

Q. And why do you not use either of those chemicals to cause fetal demise?

A. I don't think either really add to the safety of the procedure of doing the D&E or doing an deduction of labor. And they do have some risks associated with them.

Q. What are the risks of digoxin, in your opinion?

A. And my opinion is, well, you have to do an amniocentesis to do digoxin. And an amniocentesis is not without risk. The risk is small, but it is not without risks. Main risks are bleeding and infection, with infection being the primary risk.

Q. Are there any other risks associated with the digoxin injection other than just because you have to do an amniocentesis?

A. I mean, theoretically, if you don't have the needle in the right place and you have it in the uterine wall you could get absorption of the digoxin into the maternal bloodstream. And that could potentially be dangerous to the woman.

In the study by Dr. Drey, it did not have enough patients to be able to tell whether—the frequency that this would occur, if really the dose is significant enough to be dangerous.

But, theoretically, yes, it is a risk for the patient.

Q. And you also indicated there were risks from infection in providing digoxin?

[418]

A. Only in that of the amniocentesis.

Q. And do you ever—do patients ever ask you whether there is something they could use to cause fetal demise?

A. Yes. I would—I don't know what percentage of my patients, but a certainly small number of patients ask could there be fetal demise prior to the procedure. When I talk to them about what it would entail to do, most of them do not want to proceed with that. And I don't think they are particularly worried about the effects. They don't think—I think about the infection risk.

They don't think about the infection risk. They just don't want to go through that procedure, to have a needle placed, and under ultrasound guidance maybe see the ultrasound and see the fetus again. The vast majority of the patients don't want to have that done.

Q. Are you able to—would you be able to give any patients digoxin if they wanted it?

A. It depends if I could do an amniocentesis on them, because that would be the method of administering them. And in some patients, amniocentesis could be very, very difficult to potentially impossible.

If there is a fetal condition where there is no amniotic fluid or the amniotic—there is premature rupture of membrane, and that is why we are doing it, it would be very, very difficult to inject the digoxin into the amniotic space if [419] the amniotic space is basically obliterated and the only thing there is the fetus.

Additionally, some patients are quite obese, and it would be very, very difficult to do amniocentesis on.

Q. And why is that?

A. Because visualization of where you have to be with ultrasound is very difficult because you have to look through a large adipose layer, through the skin, then the uterine wall, and then the uterine cavity.

Q. So there are some women for whom you could not do digoxin?

A. Yes.

Q. And are there—is there anybody else for whom the injection is technically difficult to do?

A. Some women it is really hard to predict, but do not image well with ultrasound. And being able to see where you need to go could be very, very difficult.

And I think it is more dangerous to potentially inject something where you don't know where it is if you are not in the correct space.

Q. Do any of your patients ever ask if the fetus experiences pain during the abortion procedure?

A. Yes, some patients ask that.

Q. And what do you tell them?

A. I tell them I don't know. I don't think—I don't know how anybody can know whether there is consciousness to the [420] point we have a realization of what pain is.

I tell them that I think it is unlikely that the fetus feels pain or has the ability to interpret painful stimuli as pain.

MS. PARKER: May I approach the witness, again, your Honor, to put up another blowup?

THE COURT: Yes.

BY MS. PARKER:

Q. Dr. Doe, I would like you to take a look at this blowup, which is the operative portion of the Partial-Birth Abortion Ban Act which is at issue in this case.

Have you seen that before?

A. Yes.

Q. And can you just read it to yourself for a moment?

Are you concerned about the potential impact of this law on your practice?

A. Yes.

Q. And what are your concerns?

A. My concerns are that it is unpredictable of whether I would sometimes deliver a fetus intact to the point that it's outside of the body of the mother, and that it might still be alive when I am doing kind of a standard D&E that I do.

Q. Does the term "Partial-Birth Abortion" have a commonly understood meaning in the medical community?

A. I don't think so, because I have talked to many of my [421] colleagues and they're always like:

"I am not sure what this procedure is."

MR. QUINLIVAN: Objection, hearsay.

THE COURT: Overruled.

BY MS. PARKER:

Q. Does the term "vaginally delivers," does that have a commonly understood meaning in the medical community?

A. Yes.

Q. And what is that meaning?

A. That the fetus delivers spontaneously through the cervix into the vagina and then out of the body.

Q. And does the term "a living fetus" have a commonly understood meaning?

A. Yes.

Q. And what is that meaning?

A. That the fetus has a beating heart.

Q. Is that the same thing as the fetus being viable?

A. No.

Q. What about the term—let's see:

"In the case of breech presentation any part of the fetal trunk past the navel is outside the body of the mother"?

What does that mean to you?

A. That would mean that the fetus is kind of delivered such that the majority of its body up to its umbilicus or navel is [422] outside of the vagina with the head potentially being still in the vagina or in the uterus.

Q. So in your opinion could this law be understood as banning some of the D&E's that you perform?

A. Yes.

Q. And that you would—where you would deliberately and intentionally vaginally deliver a living fetus until, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the partially-delivered living fetus?

A. Yes.

Q. And do you have concerns that you will violate the act—what are your concerns that you will be violating the act?

A. Well, again, some of my procedures of delivering the fetus wind up delivering intact to that point. I do not know if it is alive or not, but I might do maneuvers then to deliver the rest of the fetus, that if it were alive it certainly would then kill the fetus.

Q. And do you use your D&E procedures such that this could happen when you are handling a pregnancy termination which the patient had decided to do because of a maternal health condition?

A. Yes.

Q. And is that because most of your procedures are under those [423] circumstances?

A. Almost all of my procedures are of maternal health condition or a fetal abnormality.

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[425]

* * * * *

Q. So, Dr. Doe, you indicated that this would have an impact on your practice; is that correct?

A. Yes.

Q. And what would that impact be on your current practice?

A. At this point I am currently going to stop doing D&E's, and I am going to discuss with counsel at the hospital what way I could potentially be protected, whether that is potentially joining NAFL or—

[426]

THE COURT: That is NAFL?

THE WITNESS: The National Abortion Federation League.

BY MS. PARKER:

Q. And why are you going to stop doing these procedures now?

A. Because I think it would be unpredictable for me to know whether I violate the act or not.

Q. Are you currently covered by the injunction?

A. In preparing for this case I found out that I am not covered by the injunction. I thought I was covered by the injunction, but I found out in preparing for the testimony for the trial that I am not covered by the injunction.

Q. And so as a result you are going to stop performing these procedures?

A. Yes.

* * * * *

[DR. DOE—CROSS EXAMINATION]

[430] and sometimes it's one visit.

So, my encounters with patients, the majority is not in the second trimester, but I see a large number of patients in the second-trimester.

Q. Is it fair to say, though, that in cases in which you perform abortions for either a fetal abnormality or a maternal condition, you perform them by both the D&E and the labor induction methods?

A. Yes.

Q. And is it fair to say you believe that both D&E and induction are safe methods of abortion?

A. Yes.

Q. I think you testified earlier, when asked, you tell your patients they are close to being essentially equal in terms of safety?

A. Yes.

Q. In fact, is it fair to say that you believe that both D&E and labor induction are extremely safe methods of abortion?

A. Yes.

Q. And you testified that in some cases of fetal abnormality, it's, important to do an autopsy of the fetus after an abortion is performed; is that correct?

A. Important, yes. If the couple is interested in recurrence information, and often they are.

Q. Can you—I am not sure you described that in your direct * * *?

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[432]

* * * * *

Q. And I think you testified earlier that in about 15 percent of the D&E's you perform, the fetus is delivered partially intact so that the calvarium gets stuck in the cervix; is that correct?

A. It was—I think my testimony, I believe, is approximately 15 percent would be delivered intact. Not all of those that the calvarium would be stuck; some would deliver completely intact.

Q. Do you have a—can you give me an estimate of that 15 percent how many are delivered where the calvarium does get stuck in the cervix?

A. I would probably say at least 80 percent the calvarium would be stuck in the cervix.

Q. And just to be clear, the calvarium, again, is just the fetus' head, correct?

A. Correct.

* * * * *

[435]

Q. You mentioned there were some contraindications for labor induction when misoprostol is used; those contraindications wouldn't necessarily occur if oxytocin was used instead of misprostol; is that correct?

A. Well, not necessarily. It depends on what the indication for the contraindication is. If it's for the cardiac disease that I was talking about, no, oxytocin would not be a contraindication. But, however, for a previous hysterotomy, placenta previa, oxytocin would be a contraindication for labor induction.

Q. Thank you, Doctor.

Let me turn your attention to when you are performing a D&E abortion. Is it fair to say that disarticulation or dismemberment are common characteristics of a D&E?

A. Yes.

Q. And in performing a D&E procedure by disarticulation or dismemberment, you generally use forceps to remove the fetal parts?

A. Yes.

Q. You typically use what are known as bierer forceps?

A. Bierer forceps, yes. At earlier gestational ages I might use sopher forceps.

Q. And there are—is it fair to say that there are some unusual circumstances in which you might use hern or ring * * *.

* * * * *

[DR. DOE—REDIRECT EXAMINATION]

* * * * *

[457]

Q. Well, you offer your patients a choice of two methods of abortion during second-trimester; is that right?

A. Yes.

Q. And that is induction or a D&E abortion; is that right?

A. Correct.

Q. And approximately what percentage of patients choose to have a D&E procedure?

A. Approximately 75 percent of the patients choose to have a D&E procedure with the remainder 25 percent have an induction of labor.

Q. Why do the larger number of patients want to have a D&E procedure?

MR. QUINLIVAN: Objection, your Honor. That's speculation as to why—

THE COURT: Yes, unless he knows. If he knows, he may answer.

BY MS. PARKER:

Q. Do you know why more patients choose to have a D&E?

A. In many of the patients since I am the one counseling regarding the procedure and offering the options, they often tell me why they want to have one procedure or the other. I can't say in a hundred of the cases, but in many of the cases our interaction is such that:

"No, I want this procedure because."

And often they choose a D&E—again, the majority [458] of patients choosing D&E is because, one: they don't want to go through labor. It is something that when they have been diagnosed with one of these problems it is not something that they want to go through.

Two: often many of them are very worried about seeing the fetus, and they feel that they would do better without seeing the fetus.

Three, many of them don't want to spend the time in the hospital that it would take to have an induction of labor.

Those are the majority of the reasons.

Q. Now, Mr. Quinlivan had also asked you a series of questions About a disarticulation D&E versus an intact D&E. Do you recall those questions?

A. Yes.

Q. And the way you do the procedure, do you consider those two separate types of procedures?

A. The way I do the procedure, no, I do not. I think it is a variation of one. And it happens at an unpredictable rate, whether the fetus is intact or whether it is completely disarticulated.

Q. And when the fetus is able to emerge intact, you prefer that; isn't that right?

A. Yes.

Q. And why do you prefer it?

A. Because I think the risk of injury to the patient is less [459] because there are less passes of instruments into the uterine cavity in that situation.

Q. And less passes results in what?

A. In my clinical experience—and, again, if you extrapolate from other sudden studies, which may or may not be appropriate, but the fewer times you do something that has a potential risk, the lower likelihood of that risk.

* * * * *

[DR. DOE—CROSS EXAMINATION]

[464] patients under 22 weeks you would not recommend an injection of potassium chloride; is that right?

A. She did ask me that question, yes.

Q. Now, if a patient preferred or desired an injection of potassium chloride to ensure fetal demise prior to a procedure, you would give that to her, wouldn't you?

A. Yes.

MR. QUINLIVAN: Thank you. Nothing further.

THE COURT: All right. Anything else?

MS. PARKER: No, your honor.

THE COURT: Thank you, doctor. You are excused.

THE WITNESS: Thank you.

THE COURT: All right. Were there any other witnesses for the plaintiffs today?

MS. PARKER: No, your honor. Our next witness won't be available until Monday.

THE COURT: All right. And on Monday we have doctors Broekhuizen and Creinin?

MS. PARKER: Yes.

THE COURT: And then how long do you think—in addition to the regular trial day, how much additional time do you anticipate we would need to get through both of them on Monday?

MS. GARTNER: Your honor, I think it's hard to know until we actually meet with them over the weekend to do the * * *.

* * * * *

Supreme Court, U.S.
FILED
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No. 05-1382

In the Supreme Court of the United States

ALBERTO R. GONZALES, ATTORNEY GENERAL,
PETITIONER

v.

PLANNED PARENTHOOD FEDERATION OF AMERICA,
INC., ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

JOINT APPENDIX
(VOLUME 2)

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PETITION FOR A WRIT OF CERTIORARI FILED: MAY 1, 2006
CERTIORARI GRANTED: JUNE 19, 2006

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UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C 03-4872 PJH

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. AND PLANNED PARENTHOOD GOLDEN GATE, PLAINTIFFS

v.

JOHN ASHCROFT, ATTORNEY GENERAL OF THE UNITED STATES, IN HIS OFFICIAL CAPACITY, DEFENDANT

TRANSCRIPT OF PROCEEDINGS
Monday, Apr. 5, 2004
Volume 4

BEFORE THE HONORABLE
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* * * * *

[FREDERICK BROEKHUIZEN, M.D.—DIRECT EXAMINATION]

* * * * *

[482]

* * * * *

Q. Dr. Broekhuizen, are you board certified in obstetrics and gynecology?

A. Yes, I am.

Q. Can you please tell me the places where you are currently employed?

A. I am currently employed at the Medical College of Wisconsin, which is medical school located in Milwaukee for 80 percent of my time. The other 20 percent of my time I do international health consulting-teaching work.

And in the time that I am employed at the Medical College, 30 percent of that time there is an arrangement between Planned Parenthood of Wisconsin and the medical school to have me function as the part-time Medical Director of Planned Parenthood of Wisconsin.

[483]

Q. Okay. Can you describe your duties at the Medical College of Wisconsin, leaving aside a minute what you do at Planned Parenthood of Wisconsin?

A. I am a faculty member. I am a full Professor in Obstetrics and Gynecology. I have teaching duties teaching residents and medical students.

I will lecture. I participate in second and third-year courses of certain subjects. I have a clinical practice in general OB/GYN at the Medical College. And I am located for at least one third of my time in the Division of Internal Fetal Medicine where I do mainly management of high-risk obstetrical care and ultrasound and prenatal diagnosis.

Q. And do you deliver babies as part of your practice?

A. I certainly deliver babies as part of my practice.

Q. Do you have specific niches in which you have particular expertise?

A. Well, over the years I've kind of been involved in specific niches. I—for when I was in my previous employment, I was working in a city hospital and did a lot of public health-related activities, substance abuse and pregnancy, et cetera.

I have been for close to 24 years being the Medical Director of Planned Parenthood Colposcopy Clinics for patients with abnormal pap smears. And I've developed an interest in [484] cervical cancer, detection of the precursors of cervical cancer detection.

And some of my international work relates to the detection of early cervical cancer or precancer.

My international interest, as well, includes prevention of maternal mortality due to hemorrhage. And in the Milwaukee area over the last 24 years, one of my niches has been the provision of abortion services in hospital settings.

Q. And is there a particular hospital at which you generally practice medicine as a part of your work with the Medical College of Wisconsin?

A. Most of my clinical practice at the moment is located at Froedtert—it's a—I think it's called Froedtert Memorial Lutheran Hospital.

Q. Can you spell "Froedtert"?

A. F-r-o-e-d-t-e-r-t. I am on the medical staff of about eight hospitals in the Milwaukee area.

Q. And do you perform abortions at Froedtert Hospital?

A. I do.

Q. And under what circumstances do you perform abortions at Froedtert?

A. Froedtert Hospital has its own rules about what would be allowed for pregnancy terminations. The indications there would be lethal fetal anomalies or health conditions that would [485] pose a risk to the life of the mother.

Q. Can you explain what you mean by a "lethal fetal anomaly"?

A. That would be a fetal anomaly where there is no long term meaningful life expectancy. A death would be expected within hours to sometimes weeks.

Q. And how long have you been on the Faculty of the Medical College of Wisconsin?

A. Since January of 2001.

Q. And where were you before you joined the faculty at the Medical College of Wisconsin?

A. From the end of 1979 until January of 2001, I was a Faculty Member of the University of Wisconsin Medical School, which main campus is in Madison, Wisconsin, but they have a clinical campus which is located in Milwaukee.

Q. And were you ever the Chair of the Department at the Milwaukee campus at the University of Wisconsin?

A. I was the Chair of the Department of Obstetrics and Gynecology from 1989 until 1998.

Q. And where was—the Milwaukee campus of the University of Wisconsin, where was that located?

A. It was located at one of the hospitals in Milwaukee. Over the last 24 years, the name has

changed about four times. It started out to be Sinai Hospital. Then, it merged and became Sinai Samaritan Medical Center. And currently it called Aurora Sinai Medical Center.

[486]

Q. And at Aurora Sinai, did you provide abortions in a wider range of circumstances than you currently do at Froedtert?

A. Yes I have. And yes, I do. At Aurora Sinai Hospital there are no institution-based restrictions on the indications for a pregnancy termination.

Q. And when you say: "Yes, I do," does that mean that you still perform some abortions at Aurora Sinai?

A. I still perform some abortions at Aurora Sinai.

Q. Can you explain the circumstances in which you would do abortions currently at Aurora Sinai?

A. The majority of patients are referred to me by practicing OB/GYN physicians in the community or perinatologists in the State of Wisconsin.

And if I see the patient, confirm the diagnosis and come to a consensus with the patient that pregnancy termination is the proper thing to proceed with, the indications, that's the conditions, there are situations where I cannot perform that procedure at Froedtert Hospital for nonlethal fetal anomalies, as an example. And those patients then I will provide the services at Aurora Sinai Medical Center.

Q. And you testified that you are the part-time Medical Director of Planned Parenthood of Wisconsin; is that right?

A. That's correct.

Q. And can you describe your duties and medical practice at Planned Parenthood of Wisconsin?

[487]

A. Well, Planned Parenthood of Wisconsin has a little over 30 clinics across the state. As an example, there are six in Milwaukee. Most of the services at these Planned Parenthood clinics are family planning services and cervical cancer and breast cancer screening practices.

And mainly nurse practitioners who provide theseservices, I am their direct physician supervisor and provide a lot of consultations by e-mail and by phone.

I run a problem clinic for situations that nurse practitioners cannot handle within their scope of practice.

And then, I provided the colposcopy services. I am the head of a committee of associate medical directors/physicians. All the clinics have an associate local medical director. And we kind of set protocols, and quality of care standards for the provision of mainly family planning services.

Q. And are abortions performed at Planned Parenthood Wisconsin?

A. Two of those clinics have abortions are being performed.

Q. How late are abortions performed at those clinics?

A. Up until 16 weeks.

Q. And do you personally perform abortions at Planned Parenthood?

A. No, I don't.

Q. Why is that?

[488]

A. I list for you all my interest and my activities. And it is just a matter of choosing, you know, where I spend my time.

There are other physicians who provide the services, abortion services at the two planned parenthood clinics where abortions are being provided.

Q. How long have you been the Medical Director of Planned Parenthood?

A. Since sometime in 2001, shortly after I joined the Medical College.

Q. And did you provide medical services at Planned Parenthood before becoming the Medical Director?

A. Since 1980 I have been the Medical Director for their colposcopy services. And in many ways I have, you know, been on their advisory boards. And I have—I used to take medical students to Planned Parenthood clinics to teach them family planning.

Q. You said that you also do international health work. Can you describe that work?

A. I—many years ago I worked as a tropical physician in Ethiopia. And—but in the last five, six years I have done international consulting and training work for the World Health Organization, and mainly for an organization JHPIEGO. It's a John Hopkins affiliate that does training in reproductive health, projects in practice maternal and neonatal health and in cervical cancer prevention in several countries across the [489] world.

Q. And what countries have you been focusing on recently?

A. The last three years I have worked in Thailand, Ghana and Malawi.

Q. Dr. Broekhuizen, have you published in the area of obstetrics and gynecology?

A. Yes, I have.

Q. And, generally, what subject areas have you published in?

A. I have been—when I look at my curriculum vitae, I probably will identify the areas I was interested in in general obstetrics and gynecology and high-risk obstetrics at certain time, in human papilloma virus in relationship to precancer, cervical cancer detection.

And so it has been a pretty wide range and not one—all in one particular area.

Q. And are your publications all listed on your curriculum vitae?

A. They are all listed on my curriculum vitae.

Q. Do you do medical research in the field of obstetrics and gynecology?

A. I have been involved in two. I have conducted the randomized trial with one of my residents at the University of Wisconsin. I have been involved in two multicenter studies.

And, yes, I have been involved in different research projects.

Q. And Dr. Broekhuizen, what methods of abortion do you [490] currently perform in your practice?

A. I perform first-trimester suction D&C, second-trimester D&E's and second-trimester induction methods of pregnancy termination.

Q. And in your practice, your current practice, to what gestational age do you perform D&E abortions?

A. Up until 20 weeks.

Q. And to what gestational age do you perform induction abortions?

A. Up to the legal limit in Wisconsin, which is 24 weeks.

Q. And do you ever induce a termination of pregnancy after 24 weeks with the knowledge that the fetus won't survive?

A. Yes. We will—there are situations where we will have labor induction after 24 weeks in cases of lethal fetal anomalies.

Under these circumstances usually there has been consultation with the neonatologist or the pediatric site as far as what type of support of palliative care will be provided to the newborn if it is born alive, which is inevitably going to die.

Q. And you used the term "palliative care." Can you explain what you mean by that?

A. Palliative care in that setting is really providing support of care, to provide all of the support to the mothers and the baby. And but as far as the baby is concerned, to really [491] provide an environment in which the baby can peacefully die.

Q. Does palliative care include life support?

A. Would not include life support under these circumstances, but it may include pain relief.

Q. Do you teach abortion methods to OB/GYN residents and medical students?

A. Yes, I do.

Q. What methods of abortion do you teach?

A. All the methods that I just described to you in a theoretical sense in lectures and discussions. What students and residents will observe in a practical sense depends on what cases that present themselves during their rotations.

Q. Is the performance of D&E abortions a regular part of your practice?

A. Yes, it is.

Q. How long has that been the case?

A. Since the early 1980's.

Q. Is the performance of induction abortions a regular part of your practice?

A. Yes, it is.

Q. How long has that been the case?

A. Since the early '80's.

Q. Are patients referred to you specifically for abortions?

A. Yes, they are.

Q. Can you explain some of the circumstances in which that [492] occurs?

A. The most common circumstance would be in fetal anomaly diagnosed by ultrasound or amniocentesis. The referrals would come from maternal fetal medicine specialists or OB/GYN physicians or family physicians who practice obstetrics.

Occasionally, there are referrals from specialists in other areas, like oncologists or cardiologists. If, for instance, the diagnosis of cancer in the second-trimester is made or severe cardiovascular disease where the pregnancy would complicate the underlying preexisting internal disease. But most of the time the referral would come from the primary OB/GYN physician.

Q. And why did they make these referrals to you?

A. Currently in Wisconsin, there are only four hospitals where pregnancy terminations will take place a in hospital setting.

There are probably only about four or five physicians who provide hospital-based pregnancy termination services.

And in Southeastern Wisconsin, where I am located, really only one of my partners at the medical college and myself will take the majority of referrals, I guess.

At Aurora Sinai Hospital where I used to work there are occasionally other physicians provide pregnancy termination services, but they are—really do not get many referrals.

MR. SIMPSON: We will have to object to the lack of foundation for that last question and answer.

[493]

THE COURT: Overruled.

BY MS. GARTNER:

Q. Dr. Broekhuizen, have you ever testified before in a case challenging the constitutionality of a law that restricts abortion practice?

A. Yes, I did. I was one of the plaintiffs, I think, in the Wisconsin case where there was a Wisconsin partial-birth abortion law based.

Q. And when you say you think you were plaintiff, do you just mean that you weren't—is your question—

A. I know I was a plaintiff, but I sometimes gets confused when I am a plaintiff versus an expert.

Q. Were you a plaintiff in that case?

A. Yes, I was.

Q. And why did you choose to get involved in that Wisconsin case?

A. On my reading and interpretation of the law, I was very concerned that that law could be applied to some of the pregnancy terminations I performed, would ban some of those procedures and would deprive patients from medically-necessary services.

MS. GARTNER: Your Honor, we would move to qualify Dr. Broekhuizen as an expert witness in the area of obstetrics and gynecology, high-risk obstetrics and gynecology and abortion practice.

[494]

THE COURT: Any objection?

MR. SIMPSON: Your Honor, they've included high-risk obstetrics. And Dr. Broekhuizen, as I understand, is not board certified in high-risk obstetrics.

THE COURT: Is it a requirement that he be board certified to be an expert?

MR. SIMPSON: I suppose not, Your Honor. We won't object to the designation as an expert, but we will be crossing on that.

THE COURT: All right. He will be accepted as an expert.

MS. GARTNER: Thank you.

BY MS. GARTNER:

Q. Dr. Broekhuizen, did you come here today to offer expert opinions regarding the Partial-Birth Abortion Ban Act of 2003?

A. Yes, I did.

Q. In your opinion, could this law ban some of the abortions that you do in the second-trimester of pregnancy?

A. Yes, I think it would.

Q. In your opinion, could this law ban some of the techniques that you use to treat women who are in the midst of a second-trimester miscarriage?

A. Yes, it would.

Q. In your opinion, could this law be understood as prohibiting procedures that, in your judgment, are needed by [495] your patients due to a specific maternal health condition?

A. Yes.

MR. SIMPSON: Objection, Your Honor, leading.

THE COURT: All right. I allow leading questions on the background questions. And this seems to me to be still in that area.

BY MS. GARTNER:

Q. And in your opinion, Dr. Broekhuizen, could this law be understood as prohibiting procedures that, in your opinion, are needed by your patients due to a specific fetal condition?

A. Yes, they would.

Q. And could this law be understood in your opinion as prohibiting procedures that in your judgment are needed by your patients to obtain information needed to plan for a future pregnancy?

A. Yes, they would.

Q. Dr. Broekhuizen, you've indicated that some of your patients have chosen to end their pregnancy due to a maternal health condition; is that correct?

A. That's correct.

Q. Does this sometimes arise with medical conditions that the woman had prior to becoming pregnant?

A. Yes, it would.

Q. Could you give me some examples of those?

A. It could be severe cardiopulmonary disease. What comes to [496] mind would be a condition called pulmonary hypertension where carrying a pregnancy may have a mortality risk as high as 30, 40 percent.

Patients with severe coronary heart disease. Patient with end stage renal disease, liver disease.

Q. And do some of your patients choose to end a pregnancy due to a medical condition that is unrelated to the pregnancy but is newly-diagnosed during the pregnancy?

A. Yes. Examples of that would be when a new diagnosis of cancer in the second-trimester.

Q. And why would a diagnosis of cancer lead some patients to choose to end their pregnancy?

A. The treatment for the cancer certainly would interfere, could cause—or could cause birth defects or could interfere with the normal development of the pregnancy. Or the pregnancy itself, right, would make the treatment more—make the treatment more complicated or interfere with the success of the treatment.

Q. And does it sometimes happen that a pregnancy termination is indicated due to a pregnancy complication?

A. There are situations where pregnancy complication even prior to 24 weeks would be the reason for pregnancy termination. What comes to mind would be a condition called Triploidy, where there is a total extra set of chromosomes that is in itself is a lethal fetal anomaly. But that is associated [497] with a placental condition and increased risk of early onset of preeclampsia, which is a pregnancy complication.

Q. And in your practice, in what general time frame of pregnancy are abortions for maternal health conditions performed?

A. Up till the legal limit in Wisconsin: 24 weeks.

Q. And when do these conditions tend to be diagnosed? Is there a typical time frame?

A. There is really not a typical time frame. Some of them would be fairly early terminations, because the patient is very well-aware of her serious health condition. But, for instance, in family planning, methods may fail. Those patients tend to be referred relatively early.

On the other hand, there are patients who seek or who have problems I accessing prenatal care or

unaware of their own health conditions where sometimes this may be relatively late.

Q. Do your patients ever choose to end their pregnancies due to a fetal condition?

A. I would say the majority of the terminations I perform are for fetal conditions.

Q. I think you have described a few of those, but can you just briefly describe a few other conditions that you typically see in your practice where women choose to end their pregnancies for a fetal condition?

[498]

A. Well, they would range from lethal fetal anomalies, chromosomal anomalies as Trisomy 13, or 18, or Triploidy. Lethal anomalies that are more structural in nature like anencephaly where there is no development of the brain. Conditions as renal agenesis where there is no development of any kidneys, which then leads to nondevelopment of the fetal lungs.

And then, there are the conditions as Trisomy 21 or spina bifida, which by itself are not lethal, but are diagnosed by ultrasound and amniocentesis where patients choose to have a pregnancy termination.

Q. In what general time frame of pregnancy are abortions for fetal conditions typically performed?

A. More—there has been some shift in the last 20 years. with the ability to diagnose some fetal anomalies by chorionic villus sampling or DNA analysis, at least some of the diagnosis when there is a strong family history or in high risk has been moved to be earlier part of pregnancy. But some of the structural anomalies, which I diagnose by ultrasound in patients who do not

have a priority risk, tend to be more later in the pregnancy.

Q. And is it the case that all of the chromosomal anomalies tend to be detected earlier in pregnancy with chorionic villus sampling?

A. No, that very much depends on what is the practice in a [499] given community as far as prenatal diagnosis. And it is my sense that in the midwest where I live amniocentesis is still the number 1 diagnostic tool used by patients with advanced maternal age or an abnormal triple screen, while I think on the West and the East coast there may be more chorionic villus sampling done.

But in my environment most patients with fetal anomalies are after—are diagnosed after 16 weeks.

Q. Are there particular fetal anomalies where it is in the woman's physical health interest to end the pregnancy without carrying the pregnancy to term?

A. There are diagnoses and situations where the continuation of the pregnancy will have direct—will have direct effect on the ability to deliver vaginally.

There are conditions where macrocephaly will develop where the fetal head can become so big that it will be too big to pass through the birth canal.

There are conditions as nonimmune hydrops or fetal ascites. That means fluid gets accumulated in the fetal abdomen or edema is developing in all of the fetal tissues where part of the fetal body can become so big that it would be impossible to deliver vaginally. And I would consider those situations where that is going to develop or run a test to potential to develop, especially in the context of a lethal anomaly, a maternal indication

for a pregnancy termination or [500] even earlier induction after 24 weeks to avoid surgical procedures with more morbidity and more complication.

Q. When you refer to avoiding a surgical procedure, what surgical procedure are you talking about avoiding?

A. That would be a cesarean section or a variant of cesarean section, either hysterotomy or a cesarean section.

Q. Dr. Broekhuizen, when a patient is referred to you for pregnancy termination, what is the first thing that you do?

A. Basically, in all patients I kind of collect the information that I have or I collect more information from them. And so I confirm the diagnosis. I identify the reasons why they would choose to have a pregnancy termination.

There are situations where I will ask one of my colleagues to give a second opinion about a given diagnosis. There are situations where I may do an ultrasound myself to confirm the situation.

Subsequently, I will go in detail with the patients about what therapeutic options there are. And on the more circumstances that would mean a detailed description of what a dilation and evacuation procedure would be and detailed description of what an induction method would be.

And during that detailed description I will describe the complications and risk of these procedures. I would compare that with the risk and complications of no intervention. That means continuation of the pregnancy. And [501] after that would come to a con-

clusion with the patients about what they would consider the best option under these circumstances.

Q. Do you ever—in the case where the indication for the termination is a fetal anomaly, do you talk with your patients about autopsy or genetic testing?

A. Yes. There are scenarios where there is—where it is clear from the ultrasound findings that there is a lethal anomaly, but, for instance, no cytogenetic testing, no chromosomal analysis has been done yet. That could be done before the procedure or as part of the procedure if amniocentesis is done.

Or it could be done on placental or fetal tissue after a delivery. And there are situations where there are lethal syndrome that there is a lot of problems. Or in the case of a lethal anomaly, a lethal syndrome, where a detailed autopsy would maybe make the diagnosis more correct or more precise.

And during this discussion, we often end up talking about:

> "Well, what information do you need for a future pregnancy?" Because the question that most patients have is:
>
> "Well, is this going to happen again? And what are my chances of that happening?"

[502]

And so there are situations where an autopsy and a detailed examination of the fetus is very important. And there are situations where that really is not that important.

In diagnosis and known chromosomal anomaly, we know what the qualities of the structural anomaly. If there is normal chromosomes, but an unusual syndrome, the precise nature of that syndrome is important to have that information to counsel the patient for a future pregnancy.

Q. And in addition to yourself, are other physicians involved in counseling and advising the patient?

A. Yes. As I said before, sometimes specialists in other areas, pulmonary specialists, cardiologists, cancer specialists already are involved and have discussed with them, you know, the risk of their medical disorder with continuation of the pregnancy.

In the area of fetal anomalies, it is not uncommon for us—for me to actually have the patients talk to pediatric neurosurgeons, any pediatric subspecialty related to the particular anomaly to have the patient be knowledgeable about what is the exact neonatal prognosis. Because in the nonlethal anomaly area, it is obviously the morbidity and how sick and the long-term prognosis of the newborns that can be deciding points in the patients to make decisions about continuation of the pregnancy or having a pregnancy termination.

[503]

At the medical college we have a program that's called "fetal concerns program," where patients are being referred in the diagnosis of the fetal anomaly.

And the number 1 purpose of that program is to have babies born in hospitals where neonatal surgery can be done with the highest success rate.

So this is in the context of all anomalies, right, then one encounters a lot of noncorrectable fetal anomalies. So a program like that actually attracts a lot of tragic lethal anomalies, and those are the patients that I have to deal with then.

Q. In your practice, how is the decision made regarding what method of abortion the woman will have?

A. As I explained before, I will go in—well, I make it clear upfront that I prefer not—I will do D&E's up till 20 weeks, unless there are three clearly overriding reasons that an induction would be contraindicated after 24 weeks.

Otherwise, it depends on—the patients really will make the decision about what methods she will choose. What—there are many factors that play in these decisions. Some of them are the need for an autopsy or further testing.

Other factors are the patient's personal beliefs, part of their religious belief. There are patients who really have problems with the destructive nature of a D&E procedure and prefer an intact delivery. And there are patients who have [504] strong feelings about the labor process under these circumstances, and based on their previous experience with labor may be really reluctant to undergo an induction method.

And in my opinion, the most important part is to actually ascertain their firm—their firm belief that they are doing what is best for them. And I—the best I can do is give them the risk and complications of the two

procedures so they can make an informed choice that they are comfortable with, because I consider both of those methods very safe.

And my general—even while I go in detail about the complications of these procedures, I always put a surrounding comment there that continuation of the pregnancy and going through childbirth there's a possibility of cesarean section always is a higher—entails a higher risk than any of these procedures.

Q. What, specifically, do you tell your patients about the risks and potential complications of D&E and induction?

A. Well, the three—the complications that are the most relevant to the patients are damage to the cervix or the uterus, and complications as hemorrhage and infection. And they could occur, right, in both methods.

Q. I am sorry. All of those complications could—

A. All of those complications could occur with both methods. The difference—the difference between the two methods is that the—there may be subtle differences in the incidence of [505] these complications. And many—for many patients it is actually not the complication itself, but the consequences of the complications that they are interested in.

In other words, even while the best example is the perforation or damage to the uterus has the potential, even though that is very rare, to leading to a hysterectomy.

For a patient in whom this is the first pregnancy, who clearly did not ever intend to be there at this point in time, she may weigh that complication a little higher in comparing induction versus D&E procedure versus

the patient who has already had several children, who is 44 years old, where that complication or the consequence of that complication, right, has less weight than in the first patient.

And so many patients in my experience ask me:

"Well, what would happen if that complication occurs?"

And I find that more important to actually discuss through than give them just numbers and say:

"Well, the complication rate is .3 percent for this or .2 percent for this." Patients are really interested in what it means to them as far as their future futility or childbearing. So that's basically what I do during this counseling.

Q. I think you indicated that there are some women for whom [506] labor induction is contraindicated; is that correct?

A. Well, there are patients who have a previous scar in their uterus from a previous c-section. And even while we are not—I don't think we really know what the exact incidence is of rupture of that scar with the induction methods—let's say between 20 and 24 weeks—ruptures clearly have been described and we know at term that that would be a risk of labor. And so I think that could be—that certainly would be a relative contraindication and something the patient needs to be aware of: that there is that risk.

Q. Other than a woman with a prior uterine scar, are there other situations in your practice where you consider induction to be contraindicated or at high risk for the woman?

A. When there is a placenta previa.

Q. Can you explain what that is?

A. Placenta previa is where the placenta is located over the cervix. And that is a situation where if labor were to occur the cervix would open, the placenta would separate, and that would lead to bleeding.

And in the situation after 24 weeks that would lead to a cesarean section. After 22 weeks, bleeding would occur under those circumstances, and then there would be more hemorrhage and more bleeding with the induction method than with the D&E procedure.

Q. And are there situations or conditions where the actual—[507] not where it is not the labor process itself that is contraindicated, but where the medication used to induce the labor is contraindicated?

A. Yes, there are medications being used would be generally used for induction methods nowadays would be misoprostol. And there used to be other prostaglandins. And there are conditions where prostaglandins may have undesirable side effects in patients with certain maternal conditions like severe asthma.

Q. Dr. Broekhuizen, you talked about an uterine scar being a relative contraindication; is that correct?

A. I do not think that there ever is an absolute contraindication for any of the methods. I think there are differences that are significant for individuals, and I think a relative contraindication would be a set of patients would be need to be well-informed about what complications may arise from that particular procedure.

Q. If the woman had more than one uterine surgery would the risks of labor increase?

A. The risk of rupture would increase.

Q. In addition to D&E and induction, are there any other ways of ending a pregnancy previability in the second-trimester?

A. There would be—there would be the possibility of serial dilatation, that in itself would lead to a dilatation wide enough that the fetas would deliver completely. Or that in [508] itself would initiate a labor process.

Q. And could you ever use a hysterotomy or a cesarean section method to end the pregnancy?

A. Well, that is clearly a possibility to do a hysterotomy or cesarean section, but given the circumstances that I prefer pregnancy termination most patients would not want to undergo a more major surgical procedure.

And so my goal is to avoid ever having to do that prior to 24 weeks. Now, I have done hysterotomies where inductions have failed, and so it's not that that is not an option, but it would be the last option.

Q. In those situations where you used a hysterotomy where induction failed, why didn't you convert to a D&E-type procedure?

A. Well, the induction failed, but then the conversion to a D&E procedure failed, as well. So, in other words, that was the next step, and then when that failed—those were two situations, two patients that I recall where they had significant cervical scarring from previous surgical procedures to their cervix. And it was just impossible to achieve sufficient dilatation or any dilatation at all.

Q. And, Dr. Broekhuizen, just to be clear, when you use the term "dilatation" does that mean the same thing as dilation?

A. That is the same term.

Q. Dr. Broekhuizen, you said that when you're in the process [509] of counseling your patients when they first come and see you, that you give them a detailed description of the methods of abortion that are available to them.

Could you tell us what—in describing a D&E procedure to your patient, can you tell us what you would say to her?

A. I would describe it in the following manner. I would say:

"You are going to"—depending on the time that the procedure is scheduled in the operating room—usually they would be scheduled in the afternoon—I would say:

> "You are going to come in the morning at 8:00 o'clock, and we are going to place misoprostol or laminaria or a combination of laminaria and misoprostol. Then about four hours later, I will meet you in the operating room where we finalize the procedure. In the meantime, you go to the pre-op area. The anesthesiologist will talk to you about what kind of analgesia or anesthesia you will receive during this procedure. Then, the procedure entails utilizing suction methods and instruments to remove the fetus in parts, and the placenta, in part. After that procedure and during that procedure, you will receive some medication to reduce the amount of blood loss. And after the [510] procedure

you will be in the hospital for about one-and-a-half, two hours. And then, you can go home."

And then, I will give them the instructions abou when I will see them back, and know what kind of precautions she has to take until I see her back.

We will discuss in the cases of the need for cytogenetic testing or that she agrees to have that done, analysis of some of the tissue.

There are even situations where patients have requested even with the D&E procedures prior to 20 weeks, even though there is no burial requirement in Wisconsin of less than 20 weeks, but there are situations where the patient actually ask to have clergy involved and have blessing of the remains.

And I discuss that type of support with patients.

Q. Let me ask you some follow-up questions on that. You said that you would place laminaria or misoprostol or both. How—how would you make the determination of which you would—which or whether you would place both?

A. It has evolved over the years. I used to place laminaria. Then up until about—up until 18 weeks I will only use misoprostol. After—from between 18—beyond 18 weeks I will place laminaria and misoprostol, currently.

Q. And when you use the laminaria, how do you determine how much laminaria you will place in the patient?

[511]

A. I basically will place as many laminaria as I safely can place in the cervix.

Q. And when you are using the misoprostol—are you actually—you're using the misoprostol with every D&E patient now; is that—

A. I use actually misoprostol with every pregnancy termination up until 18 weeks.

Q. Okay. And then after 18—if you are doing a D&E between 18 and 20 weeks?

A. I will place laminaria plus misoprostol.

Q. How do you administer the misoprostol?

A. I place the misoprostol vaginally.

Q. And what—can you explain what misoprostol does to prepare the cervix for the evacuation?

A. Misoprostol will have a direct local effect on the cervix and softens it and dilate it, as well as have an effect on uterine activity. And it will start uterine activity that is the combination of that will lead to a soft, pliant and often dilated cervix.

Q. Can the effect of misoprostol on the cervix be predicted ahead of time?

A. No.

Q. In your practice, have you seen that some women can deliver the fetus completely simply as a result of the misoprostol that you place prior to the D&E?

[512]

A. Yes, I have seen situations where the misoprostol led to a rather rapid labor process where in the four hours between the placement of the misoprostol and the planned D&E delivery has completely taken place. And

I have encountered situation where delivery partially has taken place.

Q. In the situations where the delivery has partially taken place before she comes into the operating room, could the fetus be outside of the woman's body in part to the extent where the fetus is out of the uterus past the fetal navel?

A. That is possible, depending on the size of the fetus and the gestational age.

Q. Could the fetus be alive at that point?

A. It could be alive.

Q. And how would you complete the procedure in that circumstance?

A. By the simplest possible extraction way. It may —the cervix may be dilated sufficiently that the delivery process can be completed by just traction, and the head will follow.

More commonly, if the trunk and the extremities have delivered, the cervix may not be dilated enough for the head, and the simplest possible compression-decompression method I would use to effect delivery of the after-coming.

Q. And would that compression or decompression method result in fetal demise?

A. If the fetus will be alive at that time it certainly would.

[513]

Q. Do you advise your patients when you are describing the procedure to them that misoprostol may have this effect of resulting in either complete or partial delivery before the actual operation or surgery begins?

A. Yes, I explain to them that there are two—well, there are two purposes of placing the misoprostol. One of them would be to avoid as much as possible mechanical dilation with metal dilators.

The second purpose would be to—advantage may be that the cervix is sufficiently dilated that it will not require many instrumental passes. And to some extent if that were to happen, that would reduce the morbidity of the procedure, in my opinion.

Q. And when you are beginning the—when the fetus doesn't deliver at all because of the misoprostol so the fetus is completed in utero when you go into the operating room when you begin the evacuation part of the procedure can the fetus be alive?

A. I think if all the misoprostol has done is to achieve dilatation sufficiently for me to introduce a large suction canula or instrument, I would assume under most circumstances the fetus is still alive.

Q. And you had mentioned talking to the woman about her choices of analgesia and anesthesia. Can you explain what those—what her choices are in that respect?

[514]

A. Are you asking about the D&E ?

Q. Yes. In the D&E context, yes.

A. Well, the choices would be a spinal anesthetic. The other choice would be conscious sedation where the patient doesn't get intubated but receives combinations of an analgetic medications and opiate-type drug. Sometimes that is referred to as twilight sleep.

And then, there would be general anesthesia. Now, in general one tries to avoid general anesthesia because that has been associated with more hemorrhage, less contraction of the uterus during the procedure and potentially higher risk of perforation or wrong passes.

But there are situations where very obese patients, in patients with sometimes more serious medical conditions where anesthesiologists will come to the conclusion that general anesthesia, they won't have more handle on complications that could arise during the surgery.

But the majority of procedures that I perform I know are done under general anesthesia.

Q. And Dr. Broekhuizen, when you begin the evacuation part of the procedure, what is the typical distance between the external part of the cervix and the vaginal opening? If it helps to refer to either of these charts, feel free to do so.

A. Well, it very much depends on the mobility. It depends on the individual patients. Having given birth certainly creates [515] more mobility to the cervix and to the birth canal. But basically one places an instrument. And I use a LS clamp on the anterior or posterior lip of the cervix. And I pull it down as far as possible, because one wants to have a straight passage for instruments.

And there are situations where actually patients in dorsolithotomy position, where the legs are up. One places the instrument where the cervix itself can come to the introitus.

There are other situations where that would only happen halfway into the vagina. And there are fairly

rarely situations where it actually may be able to be pulled outside the introitus.

Q. So that the cervix is actually out—already outside of the woman's body?

A. Correct.

Q. And do you do D&E procedures under ultrasound?

A. After 18 weeks I will always use ultrasound now. Prior to 18 weeks, not all the time.

Q. What determines—prior to 18 weeks, what determines whether you choose to use the ultrasound?

A. It's proudly my findings during the insertion of the laminaria that will help me determine. If I cannot place many laminaria, if there is something on the examination that makes me think I may have more problems identifying parts, but it is very subjective measure or a determination on my part.

Q. In performing the actual evacuation part of the procedure, [516] do you ever convert the lie of the fetus from either a vertex presentation or a transverse presentation to a breech presentation of the fetus?

A. Well, during the D&E procedure, the first part is I use a large suction curette to remove fluid, sometimes even parts of placenta will come at that time. The next step is to introduce an instrument.

And really the goal of that first placement of the instrument is to grab an extremity or any part of the trunk that I can pull through the cervix or as close as possible to the cervix.

Under most circumstances the fetal head would be the largest part, and I would not expect that I would

grab that. I do not pay attention to if it was lying sideways, if the fetal head was first or if the extremities were first. I know that at that gestational age at least half of the time it will be in a breech-type position.

And so during that process, I am sure that I influence the position, right, of the fetus, depending on what I grab and what I pull down.

Q. So it is possible that you could bring the feet down from a position that had been either an vertex or a transverse position?

A. That's clearly possible.

Q. Dr. Broekhuizen, are you aware of the fact that Congress in [517] passing this law made certain factual findings?

A. I am aware of the description of factual findings. I am not sure what these findings are based on.

Q. Are you aware that one of the findings that Congress made was that converting the fetus to a breech position during an abortion procedure increases the risk of uterine rupture, abruption, amniotic fluid embolus and trauma to the uterus?

A. I am aware that that was stated. I am at a loss to explain this in the context of a second-trimester pregnancy termination or an induction method up to 24 weeks.

I think that what's being referred to are findings and effects in the obstetrical literature if one did these procedures later in pregnancy, that that would be an association with amniotic fluid embolism and abruption.

And so I think that this applying facts and knowledge about of obstetrical practice after viability

to a situation that it really should not, has no application for it, in my opinion.

Q. So, in your opinion, is there a risk of—are there any special risks to the woman of changing the lie of the fetus during a pre-viability D&E procedure?

A. I am unaware of anything in the literature about D&E procedures that has associated the procedure with any of the complications that you've just described.

Q. Isn't—

[518]

A. And so, I think the only reference that I think I found was to Williams Textbook of Obstetrics. And, specifically, I think the chapter about some are in breech presentation. And that chapter is written about the management of birth later in gestation. And it is not written on the management of pregnancy termination by induction or D&E prior to 24 weeks.

Q. Dr. Broekhuizen, when you are evacuating the uterus in a D&E procedure, what is your objective?

A. My objective is to evacuate the content of the uterus, the fetus and placenta, with the least possible trauma to the mother in the shortest period of time.

Q. And why is it important to do it in the shortest period of time?

A. Because during this procedure, inevitably bleeding will occur. And the bleeding will probably not cease until the evacuation is complete.

Q. You also said your goal evacuation or your objective is to do this with the least possible trauma to the woman. How do you accomplish that?

A. I accomplish that in three ways. The first way is to prepare the cervix prior to the procedure. And that would be the use of laminaria and misoprostol.

The second one is to ascertain at the beginning of the procedure that I have sufficient dilatation to do the procedure. And if I don't, to actually reinsert laminaria and [519] allow more time to get more dilatation so I am not trying to force instruments through insufficient dilatation.

And the third one is to make sure that I do as few passes with the instrument as possible and achieve most of the extraction part in the lower part of the uterus. And I achieve that, as well, by at sometime in the procedure giving extra oxytocic agents that actually cause more contractions during the procedure, if that is appropriate.

But the mainstay is to achieve sufficient dilatation, right, that requires easy extraction.

Q. And do you use forceps to evacuate the uterus?

A. Well, it is not forceps in the obstetrical sense. Obstetrical forceps is an instrument that one places around the fetal head to deliver the head. It is an instrument that—it is really more a grabbing instrument. There are different types. One of them is called the sopher forceps. They are kind of round. They are kind of squared, serrated surfaces that can crush tissue and hold on to tissue. And they come in different sizes.

Q. And is the purpose of using these instruments to disarticulate the fetus?

A. The main purpose of these instruments is to bring fetal parts through the cervix or fairly close to the cervix. During this process of extraction, right,

disarticulation may take place, but it is not—that is not the primary purpose of the [520] instrument. The instrument is to provide traction.

Q. And is it—does it sometimes occur that disarticulation doesn't happen in the evacuation or extraction process?

A. Again, that depends on the amount of dilatation. If there is sufficient dilatation, it is possible that one will remove most of the extremities and trunk without disarticulation.

Q. Do you have a preference when you are doing the extraction whether it comes out intact or disarticulated?

A. I have to accept the situation that I encounter. But the least passes and the least disarticulation and least crushing I prefer, because that would eliminate boney fragments or sharp edges that in itself could, you know, do damage to the cervix or uterine wall or bleeding.

Q. If disarticulation does occur, where is the part that is actually being disarticulated?

A. That could be in the uterus. It could be in the cervix. It could be—happen in the vagina—

Q. And—

A. —outside the cervix.

Q. And depending on the distance between the cervix and the introitus, could it be outside the woman's body?

A. Sure. It is possible that part of the extremity is outside the introitus when disarticulation takes place.

Q. And in circumstances where there is disarticulation, does the disarticulation occur only at the joints of the bones?

[521]

A. Not necessarily.

Q. And does it ever happen in doing a D&E that you—that you are able to bring the fetus out without any disarticulation to the point where the calvarium lodges at the cervical os?

A. Yes, that can occur.

Q. Has that happened in your practice?

A. That's happened.

Q. And could the fetus be living at that time?

A. Again, depending on the amount of dilatation and the gestational age, it could.

Q. And could the fetus at that point be outside of the introitus to the point where at least up to the fetal navel is outside the introitus?

A. Again, depending on the consensus of the cervix that could happen.

Q. In your practice, what is the earliest gestational age where you have been able to extract the fetus intact up to the point where the head lodges at the cervix?

A. I would say 12, 13 weeks. And all have—and most—more often since the introduction of misoprostol.

Q. When that happens, where you are able to extract the fetus intact in that way, do you consider it to be a different procedure from an abortion in which

the fetus is disarticulated before that, before that point?

A. I do not consider it fundamentally different.

[522]

Q. And you may have said this, but what determines whether you will be able to bring the fetus out intact up to that point?

A. The amount of cervical dilatation.

Q. And before beginning the D&E ask can you predict if this will occur?

A. Not really. Not when I counsel the patients. Not even when I place the laminaria or the misoprostol. I probably will have a better idea the moment I remove the laminaria and I can start the extraction method. And I am more concerned there not about having too much dilatation that total delivery could occur. I am actually more concerned about the opposite. And that is that I have inadequate dilatation and would have to do multiple passes and lead to more complicated procedure.

So I am more looking at that point for the rare situation where I may have to, say, stop the procedure now and place some more laminaria and achieve more dilatation and bring the patient back in a few hours.

Q. In those circumstances where after you remove the laminaria or you examine the patient and you see that you have enough dilation that it is possible that you'll be able to bring the fetus out intact, would you ever attempt to disarticulate the fetus rather than attempt to extract it intact?

A. No. As I explained before, the least passes and the least—instrument passes, the easier the procedure, right? I would very much prefer that for maternal reasons.

[523]

Q. So in those circumstances where you are able to bring the fetus out intact or relatively intact to the point where the calvarium lodges at the cervix, is it usually possible to complete the delivery just with traction?

A. The fetal head is—I mean, all the gestational ages we are describing here is the largest part. And so it depends on the dilatation. There are situations where the dilatation may be sufficient enough where the head would follow, but most of the time that is not the case.

And so, then, depending on the gestational age, right, one has to decide what methods of compression and decompression will one use.

Q. And when you say "methods of compression or decompression," can you explain that a little more?

A. It's possible to grasp or to crush the skull at that time that would lead to release of brain tissue and collapse of the skull, and that in itself would do it.

It is possible that traction at the base of the skull will actually release brain fluids and brain tissue and brain fluids and make the skull collapse.

There are—not in the D&E's up until 20 weeks, but after 20 weeks there are other methods that I would utilize, especially in the case of fetal anomalies that had this disproportionally enlarged to decompress the head by placing trocars at the base of the skull and

really decompress the [524] unusual content of the intracranial content.

Q. Can you describe what a trocar is?

A. A trocar is a hollow instrument with a sharp edge that one can kind of push into hole. Or at least laparoscopy surgery, which most people are aware of, one introduces those in the abdominal cavity to introduce instruments to do surgery on the internal organs. That is the type of instrument. So it is a sharp—it is kind of like—well, it's a sharp point. It is kind of like a big needle. Then, the needle is inside and whole.

Q. And how long does the evacuation part of the D&E typically take?

A. That really varies a lot. It depends. I would say that on the average that that would be 15 to 20 minutes.

Q. Does—and does the time it takes, is it affected by whether the fetus is extracted intact or whether it is disarticulated?

A. Yes. It very much depends on the amount of dilatation and the individual circumstances. And so, I am sure I've been there up to 40 minutes. And I am sure some procedures were finalized in five minutes after sufficient dilatation.

Q. Have you ever, in your practice, lacerated or perforated the cervix or uterus in the course of doing the D&E?

A. I have never perforated the uterus or had to do a laparotomy after a D&E procedure. I think on two occasions [525] where there was an element of mechanical dilatation had to do repair the cervix because of a cervical laceration or the cervical laceration occurred during—as part of the extraction.

So I had to do some suture repair of the cervix.

Q. Do you know whether in either of those cases you were able to extract the fetus intact up to the head or were those more disarticulation-type procedures?

A. I am sure that these were difficult, more difficult D&E's with more passes and more disproportion between dilatation and the size of the fetus.

Q. And after you complete the evacuation with the instruments, with the forceps or other instruments, what do you do next in the D&E procedure?

A Can you repeat the question?

Q. I am sorry. After you've—after you've extracted the fetus with the forceps, what do you do next to complete the procedure?

A. Well, obviously, the placenta has to be removed, too. Now, sometimes that's already part of the placenta may actually have delivered as part of the suction that I start with. Or maybe one of the first things I grab would be the placental tissue.

But, one has to make sure that all of the uterine contents have been removed. And there is a combination of suction and feeling this and blunt curette, I try to ascertain [526] that there are no fetal or placental parts left, at least no gross, no sizeable fetal parts, because I do not think I can ever be assured that there are no small pieces of tissue or even small placental fragments left inside the uterus.

Q. What are the risks of leaving either placenta or other tissue in the uterus?

A. Would be bleeding and infection.

Q. So Dr. Broekhuizen, how do you leave D&E for now, when a patient—when you are having your initial consult with the patient, can you describe for us how you would tell her about the induction procedure and how that would go if that is what she chose?

A. Okay. In the induction, I would explain to her that she would be admitted in the hospital. That we would start the IV. That we would place medication vaginally every four to six hours, depending on the gestational age.

Q. Let me just actually stop you there. When you say she would be admitted in the hospital, would she be admitted as an inpatient?

A. Correct.

Q. And just to go back to the D&E would that be an outpatient procedure or an inpatient procedure?

A. Well, yes, the D&E would be an outpatient procedure. The admission to the hospital—actually, since some patients can go home within 23 hours for insurance reasons they often get [527] admitted as a 23 hour stay. Then, if the procedure lasts longer, then they will become an inpatient.

Q. And that is with the induction?

A. Yes, that's an induction.

Q. Okay. So I'm sorry to interrupt you.

A. But basically the patient gets admitted to an inpatient ward, which in one of the institutions is actually labor and delivery. In another institution it is part of the postpartum ward.

The patient will have medication placed every four to six hours. And I explain to them that it will

start a cramping, laboring, miscarrying type of process. For patients who have given birth before, I can explain it a little easier because they have experienced labor and no what labor pains are.

I explain to them that some physiological process that we are using medications that are really much more potent than any of the medication one would use with an induction at term.

We are kind of overriding nature because there is not—really nothing. There are usually signals at this time that suppressed uterine activity that comes from the placenta or uterus, so that the pain may be stronger.

I explain to them that given the circumstances that we can be very liberal with pain relief. We discuss epidural [528] anesthesia and IV drip with morphine or dilaudid or demerol, complete ultimate type of usually self-administered drip that the patient can use, similarly as patients who undergo major surgery and have used that for pain after their surgery.

And I explain to them that I cannot predict how long this procedure will take until delivery. It may be as short as eight hours. That may be the shortest time frame I have seen it. But I have seen it go as long as 72 hours.

I explain to them that there may be situations where we may have to convert to mechanical evacuation method or convert to the D&E or laminaria, especially if complications as infection would occur.

I explain that after delivery of the fetus we discuss the scenario of live born versus stillbirth. In most circumstances this process is strong physiological

that it will lead to stillbirth, especially less than 20 weeks.

And we discuss what kind of testing, what she would want to do, actually, as far as the fetus is concerned, what support from clergy that she wants. That does she want to hold it?

And there are many patients, especially choosing induction methods, for whom that is very important because they are experiencing this process very similarly as if they were unaware of the situation, would have been unaware of the situation, deliver a baby that is not going to live and want to [529] give all the support necessary.

After the—to go back to the technical elements, after the fetus is delivered I usually change the medication in the IV and I give high dosages of oxytocin, which is the same medication used for induction at term, but then at much higher dosages.

And then, I allow a longer time than at term for delivery of the placenta. As long as there is no significant bleeding, I am comfortable waiting up to four hours for—to wait for spontaneous delivery of the placenta.

But I counsel patients that depending on how much bleeding there is, or how much time one allows, that there may be up to 20 to 30 percent chance that the placenta may not come spontaneously at this gestational age, and we would have to remove that with an instrument and kind of do a D&C type of procedure.

Q. When you say "D&C type of procedure," we haven't had much testimony about first-trimester abortions. What is a D&C?

A. That is actually the wrong word to call it D&C procedure, because those patients' cervixes aren't dilated at that time.

It is really more an instrumental removal procedure. And under these circumstances quite often it is possible to remover the placenta intact. It just is kind of trapped there. It is not always adhering.

Q. Okay.

[530]

THE COURT: Ms. Gartner, it is time for our first break of the morning. We will take a break now. Fifteen minutes.

THE CLERK: All rise.

(Recess taken at 10:00 a.m.)

(Proceedings resumed at 10:15 a.m.)

THE COURT: All right. Please continue.

BY MS. GARTNER:

Q. Dr. Broekhuizen, I think you stated that you described to the patients that you will induce the labor with medications.

I am not sure you stated what those medications are.

A. Currently that would be misoprostol.

Q. And how would you administer the misoprostol?

A. Placed it vaginally.

Q. I think you said before the break that when you're describing the procedure to your patients that you tell them that you may have to convert to D&E techniques; is that what you said?

A. I think that I will counsel them on the fact that inductions sometimes fail, and then the alternative would be the conversion to a D&E method.

And there are situations where I know that spontaneous delivery will not occur because of gross disproportion. This would be usually in the case of fetal anomalies or as in high probability of not occurring, because [531] the fetal head or a part of the fetal body will be so big, in which I counsel we will start with the induction method. But we may then have to do other maneuvers to allow for—to create enough space for vaginal delivery by decompressing the fetal head or decompressing the fetal abnormal traits involved.

Q. Okay. I want to—just for now I want to leave aside those situations of the gross disproportion due to a fetal anomaly, and talk about other instances where in the inductions you switch it a D&E technique.

Can you describe briefly those circumstances?

A. There are circumstances where the membranes will rupture relatively easy, early in the process, where infection may occur as a result of that. Or infection may occur even in the presence of intact membranes.

But if the mother develops amnionitis, then the time frame in which the delivery needs to be achieved, right, is clearly foreshortened, because that would represent a significant risk to the patient. And achieving, no matter what method one uses, the whole goal of that is to reduce the complications for the patients and to make it the safest procedure possible.

Under those circumstances, even patients who may—who may—really their desire would be to have an intact delivery, right, I counsel them that under those circumstances, even while that is what they

would want, you know, for their [532] comfort, that under those circumstances we may have to cross the bridge to another method in order to reduce significant complications for her, and convert to a D&E procedure.

Bleeding would be another. Infection and bleeding are the two scenarios in which the timetable can become shorter. And my main goal is to have a healthy patient at the end of this procedure.

The circumstances that leads to the pregnancy terminations, in my circumstances are often already tragic..

And to—no, I don't want to expose the patients to any extra risk. And that is why there need to be flexibility on their part in understanding, right, what the goal is of the procedure, and not the procedure make the goal itself.

Q. In those circumstances, for example, where in the midst of the induction the woman develops bleeding or infection to the extent that you feel that the induction—that you need to end the procedure more rapidly, could the fetus be partially delivered at that point?

A. It could.

Q. Okay. And could the fetus still be living at that point?

A. It could.

Q. When you do then convert to the D&E techniques, how would you go about completing the procedure in the circumstance where the fetus has partially delivered but due to infection or bleeding you need to end the procedure more rapidly?

[533]

A. In the case of a partially-delivered fetus, the sufficient dilatation that I can do a compression and decompression methods to deliver the fetal head. I would, depending on the gestational age, have to choose a method that would most safely accomplish that for the patient under the particular circumstances.

Q. In those circumstances, are there options for delivering the head without using a destructive procedure?

A. Well, one option would be to continue with the induction method and wait for more dilatation, if one would not expect absolute disproportion.

But in the context of bleeding and infection, that would not be in the interest of the patient to allow more time to not effectively treat the infection.

We can give antibiotics, but best treatment of a Chorioamnionitis is not only giving antibiotics, but to the evacuate the uterus as expeditiously as possible.

Q. Have you ever heard of a technique called "Durhrssen's incisions?

A. Durhrssen's incisions is a technique that, again, generally it describes in obstetrical practice after 24 weeks. There the—where a baby in breech position is partially-delivered, but the cervix is insufficiently dilated and the head is not too big to come to the cervix where one would place—you know, cut three incisions in the cervix to basically force the [534] cervix open and allow the head to delivery.

That is a procedure that is generally used not to —if that were to occur. It is a procedure that we all hope we never have to use, because it would be kind of

like a life-saving procedure for often a premature baby in a breech presentation.

And in 2004, I think it seldom would be used because we do not delivery many breech babies—

Q. Would you—

A. —vaginally, especially not when they are premature.

Q. Would you ever consider Duhrssen's incisions to be an appropriate way in the context of an induction abortion to complete an induction where the head was trapped but the woman was infected or bleeding?

A. No, I would never consider that under these circumstances if I were to consider the consequences for the patients and future pregnancies, because that really would be purposely inflicting trauma to the cervix, which, indeed, I can repair.

But that clearly could increase the risk of any cervical problems in a future pregnancy.

And in the context of a pregnancy termination, all right, one has to balance, you know, certain risks to the mother. I think that would be a risk that one would not want to expose the patient to.

Q. Are there other techniques that are used in breech [535] deliveries at term where the fetal head gets stuck to enable the head to be developed—or to be delivered?

A. There is a method. There are methods to even with breech delivery at any gestational age beyond 24 weeks, but especially at term, there are situations where the head is deflected and there is a problem with spontaneous delivery of the head.

And there are techniques where one places a finger in the mouth or two fingers on the maxilla to actually promote flexion of the fetal head, and combine that maneuver—this is a maneuver, internal maneuver, and then have someone else push on the fetal head from just above the synthesis. Or I was actually taught to do that myself with my other hand to achieve delivery of the after-coming head.

And that, of course, is under these circumstances, a life-saving maneuver, because if part of the body is delivered and the head is still there, then we have a—there is a problem.

But that maneuver is called Mauriceau's modified maneuver. But that maneuver is really part of the obstetrical area. It is not of the techniques used for pregnancy termination less than 24 weeks for the fairly simple reason one would need sufficient dilatation for—to place someone's hand through the cervix. And that is not what we are dealing with under these circumstances most of the time.

Q Dr. Broekhuizen, you have just been describing for us the [536] D&E and induction procedures as you do them. In your practice is there an overlap between D&E and induction abortions?

A. Well, there is an overlap in the sense that induction, right, may lead to a D&E procedure under certain circumstances. The reverse is really not true.

It is an overlap in my practice that I counsel patients on both procedures. And what is most important for me is that patients choose that procedure that they are the most comfortable with.

And so I, under rare circumstances, all right, would I exclude one procedure over the other.

Q. Dr. Broekhuizen, in your practice have there ever been special circumstances where in your opinion it was safest to do the abortion in a way where you knew you had enough dilatation that you could achieve an intact extraction of the fetus up to the head?

A. Yes, there have been.

Q. Did any of those situations involve a D&E that was performed for a serious maternal health condition?

A. Yes. One of those that comes to mind was—and the one that I actually described in detail in the Wisconsin case, was for a serious maternal condition where the goal was to do serial dilatation, avoid medication for induction and avoid the traditional D&E-type method.

Q. And can you describe the medical circumstances of that [537] woman and why you considered that to be the best method of abortion for her?

A. This was a patient who had a condition of scleroderma, who had significant pulmonary hypertension, had significant other vascular disease, who was 23 weeks and one day pregnant; was transferred from another hospital to the tertiary care institution I was working at that time. She was in the critical care unit. She was very unstable. She was on multiple medications. And it was clearly felt that the continuation of the pregnancy would be—would lead to her death.

The internal medicine specialist and the pulmonologist and the cardiologist really felt that prostaglandins were contraindicated in this patient.

Q. Let me just interrupt you there. Is misoprostol a prostaglandin?

A. Correct. Were contraindicated in her situation. She thought that the whole laboring process with fluid

shifts and time would be more stressful for her than—in other words, induction was not the best option.

The option of a D&E procedure where the patient would need to have anesthesia, was already—anesthesiologists were very concerned about what anesthesia—what anesthesia method to give her. And if there was a procedure, that would have to be as short as possible with the least amount of [538] anesthesia. That was kind of the scenario we were confronted with at that time.

And I decided to proceed at that time with serial dilatation where we placed laminaria every four to six hours and the concept was that that, in itself, may lead to sufficient dilatation that we could take the patient to the operating room with minimal medication, had sufficient dilatation that we could do at least a partial extraction or maybe a total extraction.

And that is what we set out to do under those circumstances.

Q. And what actually happened with that patient?

A. That patient we placed the laminaria three times. The last time we were up to about four or five centimeters dilatation.

And when we actually took her to the operating room four hours later the fetus had completely delivered so we didn't have to—and, actually, the placenta was sitting in the cervical os. So basically we had just to grab the placenta, and the procedure completed itself.

But I would have been prepared at that time to—assuming that there would have been a partial

delivery and the head still there, to do compressing and decompressing methods.

Q. And in your practice have you treated other patients in similar situations where induction was clearly contraindicated, but this type of serial dilatation technique was in your best [539] judgment the optimal for the patient?

A. In some over 20 years, cases sometimes blur. But I think I have done at least two other cases of similar nature at less gestation age. But, again, situations where it was felt that avoiding of medication, surgery, anesthesia or minimizing that and serial dilatation would be the best method.

Q. And Dr. Broekhuizen, in your practice have there been other circumstances where your patient had compelling personal reasons for having a D&E where the fetus was removed intact and where you attempted to do that for her?

A. I had a ~~patient that~~ had was diagnosed with a lethal skeletal dysplasia.

Q. The fetus was?

A. The fetus had skeletal dysplasia form of dwarfism incompatible with survival. Most patients under these circumstances, after the counseling that I described before, since there quite often is a need for a more precise diagnosis and autopsy, we opt for an induction method.

This patient had a previous cesarean section and very traumatic birthing process the first time and really did not want to have an induction. Not so much because of the rupture risk, but really because of the experience of going through a laboring process.

And she, again—and at the same time she really was interested in having as much information. And so, we need [540] at least the trunk and skeletal part. That examination was important for her. And we decided to embark on the same method as I described in the previous case with serial dilatation, which could lead to laboring process, which would be maybe a little bit more or less painful or physiological or a significant dilatation that we could take the patient and do a partial or total extraction.

Q. And what happened with this patient?

A. The serial dilatation in the sense was so successful that, again, this patient delivered spontaneously. But it was very short time of labor perceived by her. So she was—it ended up exactly as what she had wanted it to be.

Q. And have you had other patients who felt strongly against induction, but who wanted an intact fetus for autopsy purposes?

A. Probably similar scenario. It is very rare, but one or two times.

Q. Okay. And I think you've alluded to this already in your testimony: have you performed induction abortions where you knew ahead of time that due to some type of gross fetal disproportion the head or another body part would become lodged at the cervix during the induction and you would have to complete the abortion instrumentally?

A. That probably has happened more often than the two previous scenarios. The case that I described in Wisconsin a case was a situation with a lethal chromosomal anomaly and significant [541] macrocephaly that clearly was incompatible with survival. But the head

was going to—had already reached proportions that were larger than the head of a baby at term, where the alternative would have been to do a surgical procedure like at that time that really would have been a scar as big as a cesarean section scar. Or an induction and being prepared to decompress the fetal head and to let the skull collapse to, allow for vagina delivery.

And in the context of the lethal anomaly this patient really didn't want to expose herself to a surgical procedure except if tragic development. And the plan was to induce labor. When there is that much disproportion, it's usually in a breech presentation. And to be prepared at sufficient dilatation to be decompress the fetal skull.

Q. And what actually happened with that patient?

A. That patient actually—that went according to plan. She delivered the body partially. At that time it was sufficient dilatation that I could visualize the base of the skull and insert a thin trocar to reduce the fluid. And at that point, of course, fluid and brain tissue will appear.

I think I still needed to have some—I used actually premie-type of obstetrical forceps because I still needed to create some collapsing of the skull. But I could use that type of forceps at 6 or 7 centimeters of dilatation.

Q. Did you say the trocar when you inserted it, was that under [542] your direct visualization?

A. It was under direct visualization.

Q. And was the fetus—in that case, was the fetus alive at the point when the head lodged at the os?

A. I know in that circumstance that the cord was pulsating at that time.

Q. And have you performed other similar abortions in your career where you knew that the head or another very large fetal part would lodge without being able to complete the induction without instruments?

A. Yes. This clearly has happened more often. I had a situation like this only a few weeks ago.

Q. Dr. Broekhuizen, I want to ask you a few more questions about these patients or these scenarios you were just describing.

Before I do, let me ask you: am I right that you described these three scenarios in your declaration in this case?

A. Yes, I did.

Q. And did you discuss them in your deposition in this case?

A. I did.

Q. At the time of your deposition did you also state that there were other similar cases like them?

A. Yes, I did.

Q. At any time in this case has the government requested that [543] you produce the medical records for these abortions or for similar abortions you performed?

A. No, they have not.

Q. Dr. Broekhuizen, in your opinion were these abortions where your goal was intact extraction to the calvarium, were these the safest and best options for these patients?

A. In my opinion they were the safest from the perspective of the least maternal health risks or complications.

Q. And—

A. More importantly, these were the choices that the patients made. I have had—I have done surgical procedures on patients with lethal anomalies where patients—that was their choice.

Q. When you say "surgical procedures"?

A. Like c-section or hysterotomy. They chose not to have this procedure done.

Q. So is it the case that sometimes patients choose procedures that you know carry more health risk to them?

A. Sometimes patients choose for their personal beliefs procedures that if one were to compare one complication with another would be little higher complication than the other.

And so sometimes patients weigh the medical risk of procedures, but at the same time balance that with their personal beliefs or their personal feelings about what is acceptable to them.

[544]

I am sure that religion and religious beliefs often play a role in this, and I have no problem if patients make these informed choices to do a procedure that may have a little bit higher risk than another one, because all of these procedures, right, in itself are safe compared with many complications that patients expose themself in any pregnancy and with childbirth.

Q. In your opinion, are there any special risks to extracting the fetus intact in a D&E procedure?

A. There are no—the only difference is achieving larger amount of cervical dilatation. That is the critical difference. The—it is possible that compared to the D&E the least passive of instruments would actually reduce the risk of direct trauma to the uterus.

The only fundamental difference is if one tries to achieve more dilatation.

Q. Just to put that in context, if you are assuming, say, a 22-week D&E, what would be a typical amount of dilatation that you would get for a D&E at that gestational age?

A. I think at 22 weeks one would try to achieve 3 to 4 centimeters.

Q. What about if you were doing an induction abortion at 22 weeks, how much dilatation would there be?

A. I think probably most of the time six, seven centimeters would be sufficient for delivery.

[545]

Q. And then, just to put that in the context of vaginal delivery at term, how much dilatation would you need if a woman were delivering a baby at full term?

A. Ten centimeters.

Q. And based on your clinical experience and your reading of the medical literature, can you summarize your understanding of whether cervical dilatation using gradual osmotic dilatation or misoprostol to prepare the cervix for a second trimester D&E is associated with cervical incompetence in future pregnancies?

A. My reading of the literature is this: up to 20 weeks there is, I think, sufficient evidence to conclude that with modern methods of cervical dilatation there is no increased risk of premature delivery or cervical incompetence in subsequent pregnancy.

There may be with mechanical dilatation. And after 20 to 24 weeks, I do not think that there is sufficient evidence and sufficient literature out there to make a statement for or against. Or there is no positive nor negative to my knowledge at this particular point.

Now, I need to use that lack of information when I counsel patients. And I actually counsel patients up to 20 weeks I do not think that any of the methods that we have, hygroscopic dilators or misoprostol would pose that risk. But after 20 to 24 weeks it may be there. And I counsel them that if it is, it would be a low risk.

[546]

But there are actually consultations after second-trimester terminations at that gestational age that in a future pregnancy I would recommend that their cervix gets checked serially by ultrasound; that their obstetricians are aware of this, because it is possible if that were the case to make the diagnosis maybe early enough that surgical cerclage could be placed, and the next pregnancy could be saved, if that condition were to occur.

Q. Dr. Broekhuizen, if there were an increased risk of cervical incompetence after 20 weeks, do you think that risk would be enough to make the abortions at that stage unsafe?

A. No, I do not think that that would—it would not —if—I doubt that that risk would be higher than the risk associated with large conizations of the cervix or a

large LEEP procedures, if there is an association there. And that is controversial, as well, because it depends on the size of tissue that is removed.

And so, I do not think that whatever that number would be, that that ever would be in a range that one would consider the procedure unsafe in comparison with of course the indications for the pregnancy terminations that the patient is facing.

Q. What is a LEEP procedure? Could you spell that, first?

A. It's L-E-E-P procedure: loop electrosurgical excision procedure. It is a procedure that is usually used for the [547] treatment—sometimes diagnosis and treatment of a precancerous condition of the cervix where part of the cervix is removed with an electrical loop.

And sometimes precancer of the cervix can extend into the cervical canal, and that has to be removed pretty high up there where one could lose, let's say, half of its cervical length.

And, again, there is a concern: can that lead to weakness of the cervix in a subsequent pregnancy?

Q. When you say that you have patients that are having abortions after 20 weeks and you counsel them that:

> "We don't know about the risk, but there could be a risk," do you do that for both D&E and induction abortions?

A. Yes, I do.

Q. And is this—is that, the uncertainty about that, an important consideration for your patients?

A. I don't—I cannot recall any patient for whom that ever has been the deciding reason to undergo or not undergo a pregnancy termination at that gestation rate, because the reasons for the pregnancy terminations are usually very clear to them and would override this concern.

Q. Okay. And then, just talking, again, about those three scenarios: the woman with scleroderma; the woman with the fetus with skeletal dysplasia; and the very high macrocephalic, [548] hydrocephalic fetus, is there a particular term that you use to describe the method of abortion that you have used in those cases?

A. I assume you mean to describe it to the patient.

Q. Yes.

A. No, I try to, in the most gentle way, explain what I may have to do. I mean, these are not easy discussions that I have with patients. These are—there is a lot of tears shed during many of my counseling sessions.

And so I describe it in a factual sense, but I don't really coin it with a phrase or a term or a medical term.

Q. Okay.

MS. GARTNER: Your Honor, may I approach to put the copy of the Act up?

Thank you.

THE COURT: Are you moving to a new section?

MS. GARTNER: I am.

THE COURT: I would like to ask a few questions on this last subject before I forget.

Doctor, you described a couple of situations where you used what you call "serial dilation" to achieve a greater level of dilation of the cervix so you could attempt to remove the fetus intact or at least partially intact.

My question is: have you had occasion to deliver the fetus intact or partially intact when you have not used [549] serial dilatation? In other words, when you are simply preparing for a regular D&E, have you ever had the occasion to remove the fetus intact or partially intact unintentionally?

THE WITNESS: Not without any medication unless the patient spontaneously would have started the miscarrying process. That has happened, too.

In the context of the diagnosis for which I do pregnancy terminations like fairly serious fetal anomalies it is possible that between the time I see the patients and the procedure ceases spontaneously. They will do that.

In the context of the D&E, if I understand your question, I think counsel asked that question before. When you start the misoprostol to prepare the cervix in that preceding hours, it is possible that in itself will lead to sufficient dilatation. But I already call that an intervention, because the misoprostol is part and parcel for the procedure.

THE COURT: There is a certain amount of misoprostol that you use and a number of laminaria that you use to achieve a dilatation of three to 4 centimeters for a regular D&E; is that correct, say under 22 weeks?

THE WITNESS: Yes. You cannot really predict what dilatation you will achieve, but in most cases you will achieve 2 or 3 centimeters using misoprostol or—

THE COURT: I think my question is simply: has it been your experience that you only essentially performed an [550] intact D&E only in those circumstances in which you sought to perform an intact D&E at the outset?

THE WITNESS: No. It has happened—it has happened after placement of laminaria or misoprostol as a prelude to the surgical part, the evacuation part. It has happened in the intervening time. So I have seen that happen.

THE COURT: Even though when you placed the laminaria, that was not your intent?

THE WITNESS: Correct.

THE COURT: All right. My other with question was: Do all of these second-trimester abortions that you perform, are they the result of a maternal or a fetal health condition?

THE WITNESS: Yes.

THE COURT: All of them.

THE WITNESS: All of them.

THE COURT: Okay. All right.

BY MS. GARTNER:

Q. Dr. Broekhuizen, I would like you to look at this chart which has the operative definition of the law that is at issue in this case. And did you have a chance to read it?

A. I have read this part.

Q. Okay. Are you concerned about the potential impact of this law on your medical practice?

A. I am very concerned about the potential impact of the law on my practice.

[551]

Q. Could—in your opinion, could this law be understood as banning some of the D&E's that you do?

A. I am very concerned that the law would ban some of the procedures I just described.

Q. Just to follow up on Judge Hamilton's question, are you concerned about this law only in those cases where—the impact of the law only in those cases where you do the serial dilatation with the intent of getting to the point where you know you'll have enough dilation to bring the fetus out intact, or would you think it would also apply to the other D&E's where you may or may not have enough dilation to bring it out intact?

A. I think it's—my concern in both scenarios. I am concerned in the situations that I described as in the three cases where that was—the goal was to achieve partial delivery or possibly intact delivery.

But I am as well concerned about the application of this language and this procedure to any D&E procedure, where this could happen without that being the primary goal.

Q. And in your opinion could this law also be understood as banning some of the induction abortions you do?

A. It would. I would be very concerned that it would ban some of the induction methods in which I know that I have to convert to an element of—maybe not an element. Where it would include part—the situation where I can anticipate that there will be partial delivery, and I know that there is going to be [552]

an interrupt body part. And it may not just only be the head. I can think of situations where there would be disproportion in the fetal abdomen that would preclude delivery that I may have to decompress.

Q. Are you concerned about the impact of this law in those situations where you described where in an induction the woman starts to bleed or become infected and you need to convert the procedure to a D&E?

A. I would be concerned for the same reasons.

Q. Dr. Broekhuizen, the definition of partial-birth abortion describes two, two scenarios in terms of the fetal presentation. It talks about delivering a living fetus until, in the case of a headfirst presentation, the entire fetal head is outside the body of the mother. That is the first scenario.

And the second scenario is in the case of a breech presentation, any part of the fetal trunk past the navel is outside the body of the mother.

Are there circumstances in your practice where you've done an induction where the fetus presents in a headfirst or breech—I am sorry—headfirst or vertex presentation. And after the fetal head is outside the body of the mother, as stated in the law, you must do a destructive act to complete the procedure?

A. Yes, I have encountered that situation. There are conditions as nonimmune hydrops or conditions where there is [553] fetal ascites where there is significant amount of fluid in the fetal abdominal cavity that would lead to the abdomen being too large. Or a cystic malformation where there's a fluid-filled area. These both are lethal conditions, and I have had to use Trocar or spinal needle to decompress part of the fetal chest

and abdomen where the contents—in order to achieve delivery of the remainder of the baby.

Q. And was that after the head had fully delivered through the cervix?

A. That's, in these situations, the only way that one can actually do the decompression if the head is not only delivered through the cervix. If the head was actually delivered through the introitus, because I need to have the space to reach the disproportionately large abdomen.

These are fairly rare situations, but they—these are some of the more serious, you know, disfiguring fetal anomalies that one can encounter.

Q. And you have encountered them in your practice?

A. Correct.

Q. In the abortions that you have done using serial dilatation to ensure the intact fetus, knowing that you might have to use a destructive act to deliver the head, did you deliver the fetus to that point for the purpose of performing the destructive act?

A No. My—not for the purpose, because if there—if [554] there would have been the situation where I didn't have to do that, where the head delivered spontaneously, I certainly would have preferred that.

But in certain scenarios, it is improbable, right, that the head will deliver. So it is the disproportion—let's say I described a case where the fetus head was really very disproportionate. But at 21, 22 weeks with induction method there often is enough disproportion that at the dilatation of five, six centimeters the trunk will deliver but the head will not.

So it is—while it is not absolute disproportionately, right, there is relative disproportion.

But under those circumstances, I have seen, even with the disproportion, the spontaneous delivery. But I have seen situations where that did not occur, and then I am faced with the choice of expediting the procedure at that time or not.

And that's why I need to discuss that with the patient, that option may or that situation may arise.

Q. In your practice, do you ever bring the fetus partly but not entirely out of the uterus for the purpose of doing a destructive act?

A. Not for the purpose of doing a destructive act, but I need to be prepared to have to do a destructive act.

Q. Does your purpose in evacuating the uterus vary by whether [555] you are doing a D&E procedure or an induction procedure or the serial dilation-type procedure that you described?

A. The purpose is to evacuate the content of the uterus in the safest possible way for the patient with the least complications, regardless of what methods I would choose or regardless what method the patients would prefer I use.

Q. Okay. Dr. Broekhuizen, do you ever treat women who present to you in the midst of a spontaneous second-trimester miscarriage?

A. Sure I do.

Q. And would the treatment that you offer to those women ever be covered by this law as you understand the law?

A. I think if patients present as a spontaneous second-trimester miscarriage, if in the absence of bleeding or infection, I would probably let the process naturally take place.

But in the scenario of infection or significant bleeding, I may be confronted with the situation that would be fairly similar as if I did an induction method pregnancy termination where I have to convert to a D&E procedure for maternal health reasons because now continuation of the natural process or continuation of an induction process will take more time, and in the context of bleeding or infection may increase her health risks and would increase the morbidity.

So I can think of the scenario where I would be [556] confronted with the same dilemma that I may encounter in the plan's pregnancy termination by an induction method.

Q. In ending the pregnancy using D&E techniques, is it possible, then, that you would extract the fetus to the point where the fetus is outside the woman's body past the fetal navel?

A. Again, if one were to convert, one would want to extract the fetus in the most safest and most expeditious way with the least potential risk for the mother. And then, since it is the extraction portion that would be the least risky part, right, one could encounter that same situation.

MS. GARTNER: Your Honor, may I approach to put up the other part?

THE COURT: Yes.

BY MS. GARTNER:

Q. Dr. Broekhuizen, this is the beginning operative section of the statute. The second sentence of this subsection, which is Section 1531(a), includes what is called "the life exception" to this law. If you could read that second sentence?

A. "This subsection does not apply to a partial-birth abortion that is necessary to save the life of a mother whose life is endangered by a physical disorder, physical illness or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself."

[557]

Q. In your opinion, would this life exception enable you to perform the abortions that you currently perform in all situations of serious maternal health conditions?

A. Well, what troubles me about this language is that it is not clear to me who determines the necessity. Who defines what is necessary to save the life of the mother? What is the actual risk, you know? Is that a percentage, risk of mortality?

It certainly doesn't cover health complications like increasing the risk of needing a new kidney transplant in a sooner period of time. But as far as the right, so that troubles me, too. But who determines the necessity, and what is really "life endangerment" is what troubles me.

I think that I have seen patients, since I take care of patients who take very high risks in continuation of pregnancy. I have seen patient take risks that are as high as 30 percent. And I have seen patients who consider the risk of 2 percent of death insignificant

risk compared with the normal background risk of dying from being pregnant.

And I think that the personal choices and the personal circumstances that people have, the determination of what death may mean for their children, for their families, varies so significantly that I think that the only person who really can determine what risk for life one would take is the patient itself.

[558]

And then, how one reduces that risk would be up to me and the patient by what method to do it.

So in other words, that's—I would be very uncomfortable, because I would think that anybody could say:

> "Well, that wasn't necessary," while it was very necessary for that patient with those particular circumstances.

Q. Dr. Broekhuizen, you referred to or alluded to health conditions that might lead to the patient needing a kidney transplant sooner than otherwise. Was that —were you referring to a particular type of medical situation there?

A. Well, there are situations where people will have preexisting renal disease or, say, in the context of systemic lupus, where the process is an ongoing process, where the pregnancy may speed it up or the patient may be unwilling to accept that process.

So, there are situations where the issue is not life, but the issue is really health. And how does the pregnancy—how potentially can it effect the progression of the disease that the patient already has.

And, again, patients there will make individual choices about what they will accept as a health risk or not.

Q. Dr. Broekhuizen, thinking back to the patient you described, the first patient you described where you did the serial dilatation, the woman who had—I think had scleroderma and some other medical conditions, do you believe that this [559] exception would have applied to that patient?

A. I certainly would hope that exception would apply to that patient. There were at least five or six physicians involved in coming to the conclusion that this really represented a life-threatening—very immediate life-threatening risk. Not a life-threatening risk a few weeks down the road, which is more often the case.

But I am concerned that someone would take the position that it has to be at least 75 percent certain and may not have—may have taken the position that it wasn't necessary.

I don't know who is the best judge beyond the patient and the physician that she is making a choice with. Who can make—I don't think of better people who can make that choice than those two.

Q. And in the case of that patient with scleroderma, even if the induction was contraindicated for her because of her medical conditions, was hysterotomy an option for her?

A. Actually, the anesthesiologist and the pulmonary specialist and the critical care specialist and the cardiologist all felt that given the patient minimal amount of anesthesia or complications that could occur from the surgical procedure would be higher than any risk that could occur from the serial dilatation.

MS. GARTNER: Your Honor, may I approach the [560] witness?

THE COURT: Yes.

BY MS. GARTNER:

Q. Dr. Broekhuizen, I am handing you a copy of the entire act that is at issue in the case. And I have turned it to page S3-7, which is the second to last page. And I would like to direct your attention about two-thirds of the way down the page to the paragraphs that are marked "d-1" and "d-2."

If you could just take a look at those briefly.

A. I am reading them.

Q. Okay. Do you understand that these sections allow a physician who has been accused of violating this law to seek a hearing before their state medical board on whether the abortion was necessary for the woman's life, and that the findings of the state medical board could be made part of the record at the physician's criminal trial?

A. I am reading that that is in the law.

Q. Does the existence of this procedure before the state medical board give you any comfort that the abortions that you do to preserve maternal health or that you believe are necessary for the woman's life would not be found to violate this law?

A. I am not comfortable at all with this language as a protective mechanism, because it seems to me I would be indicted first, and then I would be subject to a hearing by a [561] state medical board of which I really do not know what experience, expertise they have in this particular situation.

And it is my understanding that—and so I think that it would indict me first, and then the mechanism of—the mechanism by which the state medical board could then decide I did the right thing already would have had significant impact on my ability to provide similar services to patients or probably could effect my career in a significant fashion.

Q. Dr. Broekhuizen, is it your understanding that you could avoid the reach of this act by inducing fetal demise before you begin the evacuation part of the D&E procedure or the induction procedure?

A. Yes. That would be a way of avoiding the consequences of this act.

Q. Do you discuss with your patients the option of inducing fetal demise by injecting digoxin into the fetus before the abortion?

A. Yes, I do.

Q. And do all of your patients choose to have fetal demise induced?

A. No, not all of my patients choose to have fetal demise induced.

Q. And why—

A. There are actually patients who do not want fetal demise induced.

[562]

Q. Why is that?

A. Especially in the context of the patients with lethal anomalies, patients do not feel that they need to witness a lethal injection, which would be under ultrasound guidance, and actually prefer to have an earlier delivery of a baby that cannot live. And some of them

actually do not mind if there was signs of life. And some patients have even expressed that that is what they would prefer to let the baby die in their arms.

And I think in some religions there is a difference between blessing and baptizing, and so there are patients who actually will travel from one—from Madison, Wisconsin to Milwaukee after the diagnosis of fetal anencephaly, because in one of the hospitals there they have a rule that it needs to be done after 20 weeks. And patients actually really choose not to have that done.

On the other hand, there are patients who—for whom that is a very comforting procedure to have taken place, you know, as part of the practice of termination procedure.

But, again, this is a very individual choice that patients may make on their set of beliefs and their comfort level.

MR. SIMPSON: Objection, Your Honor, as to lack of foundation and hearsay as to the religious beliefs and practices.

[563]

THE COURT: Overruled.

BY MS. GARTNER:

Q. Dr. Broekhuizen, one final question: if this law were enforced, what impact would it have on your practice and on your patients?

A. Well, it would—it certainly would make it more difficult. It would make it significantly more difficult to provide the medically necessary services that some

patients choose under the circumstances that I perform pregnancy termination.

And so the alternative of the lethal injection, right, would probably become more prominent. I would probably have to utilize that more to avoid the consequences of the law. But as I just explained, that may not really be in the best interest of the patients and what they would choose as the best method.

* * * * *

[571] * * * deposition.

A. Yes.

Q. And if you could read silently, please, lines 20 through 24 on that page.

A. I am reading them.

Q. Is that what you testified?

A. Yes, I did.

Q. And you said at line 20:

"QUESTION: Well, I can go on, just go on with the question. To follow up on that, are there instruments that you use for D&E that are specifically meant for dismembering the fetus?

"ANSWER: Yes, I do. Yes, they exist."

That is what you said?

A. Yes.

Q. So there are instruments specifically meant for dismembering the fetus?

A. Yes.

Q. Doctor, you've done approximately four or 500 D&E abortions; is that correct?

A. That's correct.

Q. What percentage of those abortions, of those D&E's involved some degree of dismemberment of the fetus?

A. I would say over 90 to 95 percent of the majority of cases.

Q. As far as you know, Doctor, you have never left fetal parts [572] after a D&E, have you?

A. To the best of my knowledge I don't, and I try to ascertain that I didn't leave any parts at the end of the procedure.

Q. And to the best of your knowledge you have not?

A. To the best of my knowledge I have not.

Q. Doctor, you believe that a physician can avoid leaving fetal parts in the uterus by doing a careful procedure in inspecting the parts carefully after evacuation, correct?

A. I think careful inspection allows for ascertaining that extremities, trunk, fetal head are there. I am not so sure there would not be part of fetal organs or small parts that are still in the uterus.

Q. The physician should be able to avoid that by doing a careful procedure and inspecting the parts carefully afterwards.

A. Yes. The goal is to make sure that there are no large—that to the best of your ability to see, most large parts are removed. It's similar looking at all the placental parts. One tries to reconstruct and feel all the placental parts are there.

And actually it's the feel inside the uterus. I use a blunt curette for that. That gives me the most com-

fort level that I haven't left any fetal parts or placental tissue behind in addition to the inspection.

Q. And by doing a careful procedure and a careful inspection [573] afterwards the physician should be able to avoid leaving any fetal parts inside the uterus?

A. The incidence of leaving fetal parts or placental parts should be minimal, but it is never zero.

Q. Doctor, if I could refer you to page 83 of your deposition.

A. Yes.

Q. If you could read to yourself lines 20 on that page through line 4 on page 84.

A. Which? Where do you want me to start?

Q. Again, silently, page 83, line 20, through page 84, line 4.

Is that what you testified?

A. That is what I testified.

Q. You said, question on line 20:

"Is one of the potential complications of D&E the retained fetal parts?

"ANSWER: That would be a complication if—I wouldn't consider it a complication. I think under—if one does a careful procedure, one should be able to not have that happen by careful inspection of all of the tissue and products that have been evacuated. So I always very carefully inspect what has been removed and try to avoid that from happening."

Is that what you said?

A. That is what I said.

[574]

Q. So the physician should be able to avoid leaving fetal parts by doing a careful procedure and a careful inspection?

A. That is what I said. I am reading ahead of myself here, what I said, but in the next answer I said:

"It is possible that it can happen." But—

Q. And you also said, did you not, Doctor, on line 7 on page 84:

"I think that one is not supposed to leave anything behind," correct?

A. That's correct.

Q. Now, Doctor, usually—I believe you've testified that after doing a D&E you examine the fetal parts, correct?

A. Correct.

Q. Usually in examining the fetal parts you don't actually see the bones, do you? You usually see the limb and the actual bone is in the limb?

A. You can sometimes see bone. Sometimes you can see just the limb.

Q. But usually you just see the limb, and the actual bone is in the limb?

A. Actually, when disarticulation takes place in the joint one can certainly see the end of the bone on inspection.

Q. The end of the bone. But usually the rest of the bone is inside the limb?

A. There are situations where actually the bone is crushed in * * *.

* * * * *

[577] * * * agreed with that statement.

THE COURT: Okay. All right.

BY MR. SIMPSON:

Q. Doctor, is it true after reading this testimony that the use of ultrasound makes the D&E much easier and much safer?

MS. GARTNER: Your Honor, I am sorry. I think Mr. Simpson has mischaracterized the deposition testimony. And so as what Mr. or Dr. Broekhuizen stated was on page 87, lines seven, eight, nine and ten:

> "That there are unusual situations where the ultrasound makes it much safer and has made the procedure much easier."

MR. SIMPSON: I will move on to the next question.

THE COURT: Thank you.

BY MR. SIMPSON:

Q. Dr. Broekhuizen, the use of ultrasound decreases the risk of injuring the patient with your instruments, correct?

A. Can you repeat that?

Q. The use of ultrasound decreases the risk of injuring patients with your instruments?

A. The use of ultrasound will allow me to avoid misdirecting the instruments that I place in the uterus.

Q. Thus reducing the risk of injuring the patient with your instruments?

A. That's correct.

* * * * *

[582] * * * examine the brain for pathologgical purposes?

A. That's correct.

Q. Isn't it true you sometimes choose to use a surgical abortion procedure in which you purposely deliver the fetus intact up to the head?

A. Can you repeat that question?

Q. Certainly. Isn't it true that you sometimes choose to use a surgical abortion procedure in which you purposely deliver the fetus intact up to the head?

A. I don't think I—I think I have answered the question on the direct. I think in a surgical procedure my goal is to evacuate the uterus in the simplest and safest way. And that it can occur that with sufficient dilatation I can deliver the body up to the head.

But that is not necessarily the purpose of the D&E procedure.

Q. Let's make sure, first of all, Doctor, that we have defined one or two terms. By "surgical abortion," we mean abortion with instrumentation, correct?

A. Correct.

Q. Induction is not surgical abortion?

A. That's correct.

Q. Doctor, do you sometimes choose to use a surgical abortion procedure in which you purposely deliver the fetus intact up to the head?

[583]

A. I have chosen—yes. The answer is: yes. The cases in patients with scleroderma and skeletal dyspla-

sia, it was the serial dilatation part that would consider the surgical if one were to define it as a surgical abortion or part of a surgical abortion. That was the mainstay of that approach.

But there the goal was to deliver as much of the fetal body in the particular circumstances of that case, that's correct.

Q. And, Doctor, this procedure in which you purposely deliver the fetus intact up to the head, you refer to that as "intact D&E," correct?

A. I don't think I have used the word "intact D&E" today. I may have used it in previous deposition, but I don't recall that I used that particular term today.

Q. You do refer to that procedure as "intact D&E." I am not talking about today, necessarily, but just in general?

A. Yeah. I may have referred to that procedure in that sense.

Q. And then, when you choose to use that procedure you then sometimes have to compress the head to complete the delivery, correct?

A. Sometimes decompress, sometimes decompress and compress.

Q. Doctor, you testified earlier that sometimes parents want an intact fetus for blessing or burial. Have you ever had the parent express that desire where you had compressed the head of the fetus to complete the delivery?

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[584]

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Q. Now, doctor, this procedure that you sometimes choose to do in which you purposely deliver the fetus intact up to the head, that is a new procedure, correct?

A. Not for me.

Q. Are you familiar, doctor, in the medical literature with references to what is sometimes called "intact D&E," sometimes called "intact D&X"?

A. I am familiar with the literature and the terminology.

Q. And that is a new procedure?

A. It is described. I don't know. It is not a new procedure in my practice. I have had to deal with situations in my practice in Africa in the '70's. And I have had to deal with fetal anomalies in the early '80's, that are similar to the situations that I described. And I have used very similar [585] methods and parts of techniques, albeit different medications and different instrumentation. And so conceptually for me this is not new.

What is new is the fact that it was kind of described as new or different from the destructive D&E procedure by other people who described it.

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[587]

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Q. As you say here, doctor, the intent—the use of serial dilatation to achieve sufficient dilatation to remove the fetus in intact is a new procedure?

A. I have problems answering this question. The patients with scleroderma, I performed the procedure before I ever read about Dr. Haskell's new procedure.

I would think that anybody who has performed pregnancy terminations for the indications—and I have been performing them for the last 20 years, right—has utilized elements of what Dr. Haskell describes.

I have never, you know, started some pregnancy termination listing concepts:

> "I just read about a new procedure written by Dr. Haskell, and I am going to do exactly what he was describing there."

[588]

And I think that would be true for many physicians who perform pregnancy terminations in the last 20 years for the indications that I described.

Q. Dr. Haskell gave his presentation in 1992, correct?

A. I don't know. I forgot.

Q. Are you aware, doctor, of any descriptions either in presentations or literature, any descriptions of Dr. Haskell's procedure before he made his presentation?

A. No. I am unaware. All I know is there are things that Dr. Haskell described that I know I did before. Maybe not in the sequence as described or in the sequence described by the ACOG.

Q. Doctor, the intact D&E procedure as you use it is characterized by serial use of osmotic dilators to achieve a greater degree of dilatation than you would do for a D&E by dismemberment, correct?

A. That's correct.

Q. So you do not normally use serial use of osmotic dilators in surgical abortion in the second-trimester?

A. I will only use serial dilatation if I find that after the first dilatation that I have not achieved sufficient dilatation to proceed in a safe manner for the procedure.

Q. And you always use serial dilation when you have chosen to use a procedure in which you purposely deliver the fetus intact up to the head?

[589]

A. Yes.

* * * * *

[591]

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Q. Now, the first of those three cases I believe you testified earlier was a woman at 23 weeks, one day, who had scleroderma?

A. Correct.

Q. And one of the reasons that you wanted to do an intact [592] removal in that case was that a D&E involving disarticulation requires more instrumentation than intact D&E, correct?

A. And more anesthesia.

Q. And you believe that intact D&E carried less risk of causing damage to the uterus?

A. In that particular case, a surgical procedure like hysterotomy, induction and a D&E, conventional D&E procedure all in the opinion of physicians taking care of her carried more risk than the serial dilatation is the purpose of avoiding any of the anesthesia, prostaglandins, and allow partial delivery and then com-

pressing of the fetal head, which ultimately wasn't necessary.

Q. And you believe that intact D&E carried less risk in causing damage to the uterus?

A. That was not the primary reason. In this particular case, it was the fact that, one, if complications were to occur, like bleeding during the procedure or the anesthesia and analgesia necessary would make the patient more unstable than if this happened without utilizing any of these techniques.

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[598]

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A. My intent was to do serial dilatation and achieve sufficient dilatation that I could do a total or partial extraction.

Q. And the patient suffered no ill effects as a result of that procedure?

A. No. The patient's recovered from the procedure and actually became better. Her medical condition improved. She was able to be extubated. She died from her—I happened to know that she died from her disease 18 months later.

Q. So, really, Doctor, as it turned out an induction could have been performed from the outset in that instance?

A. No, I would strongly disagree with that.

Q. Are you telling me, doctor, that the serial dilatation of the cervix did not lead to any uterine contractions?

A. I am sure the serial dilatation led to some degree of uterine contractions, but this significant less side effects or [599] potential adverse effects than the medication that one would have to use if one set out to do an induction.

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[601] * * * contraindication. So it was not absolutely contraindicated. It was really the patient's request.

Q. And, in fact, I believe you testified to this earlier: the serial dilatation prompted labor to start, and she delivered the fetus intact without your using any instrumentation?

A. That's correct.

Q. So it really became an induction?

A. It became a total expulsion of the fetus without using the usual medications for an induction, which would be a prostaglandin or high-dose oxytocin.

Q. Wasn't misoprostol used in that case, Doctor?

A. No.

Q. Are you telling us, Doctor, that you disagree with the statement that that procedure kind of converted into an induction?

A. No. I think ultimately—I—my definition of what an induction is that one from the onset uses medication to start contractions that then leads to dilatation and expulsion of the fetus.

All right. This is—I would describe this as a serial dilatation with the intent or with the goal to do an extraction that led to enough prostaglandin release that led to spontaneous expulsion and neutron activity,

which I think is different, which are two different starting points and two different end points.

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[603]

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Q. Hydrocephaly is an excess of fluid in the skull, correct?

A. Correct.

Q. It is not necessarily fatal to the fetus, hydrocephaly?

A. Not necessarily. But in this situation it was associated with a chromosomal anomaly, yes.

Q. Doctor, one can deliver a living hydrocephalic infant vaginally by draining the excess fluid with a needle, correct?

A. Not necessarily.

Q. And in what cases can that not be done?

A. It really depends on how—it really depends on how macrocephalic the head is and how extensive the calvarium is distended.

One can drain the fluid, but that—there is the point of reaccumulation of the fluid. And that will happen during an induction period. And there is the issue that sometimes even while the fluid is drained the skull may not simultaneously collapse. It still may require some traction or some additional manipulation.

* * * * *

[611] * * * the standpoint of the mother to kill the fetus in the process, correct?

A. It's—you are now referring to pregnancy terminations before 24 weeks?

Q. Or after 24 weeks, if there is some reason for it.

A. After 24 weeks, if there was a lethal fetal anomaly, right, we would—that would be in the context of the palliative of care, and that would be a different scenario.

If it was after 24 weeks and there was no fetal anomaly, right, and pregnancy termination at that point was necessary, obviously I would make all the effort to actually make sure that the baby had all the options to survive.

At less than 24 weeks, right, that would be not necessary.

Q. So just to clarify, concrete example. Let's say the fetus is anencephalic, all right? The woman is at 24 weeks, and the decision is made to terminate the pregnancy. There is no medical reason from the mother's standpoint to ensure that the fetus dies in the course of the abortion.

A. That would be correct in that scenario.

Q. Now, Doctor, you've testified, I believe, that you believe intact D&E reduces the use of anesthesia, reduces blood loss and reduces the risk of complications as compared to D&E by dismemberment? For each of those risks—

A. I think I said "it may." I think I said as well that we [612] really have no comparative series that we could call to some reliability.

Q. Doctor, your belief regarding the use of anesthesia is based on a belief that intact removal is quicker than dismemberment, correct?

A. That's correct.

Q. None of your patients who have had a D&E by dismemberment have ever had a complication from anesthesia; isn't that right?

A. That's correct.

Q. So it would be fair to say in your view as far as anesthesia is concerned, that intact D&E presents a hypothetical benefit, correct?

A. Well, the two patients out of the three never—really, none of these patients ever had anesthesia.

Q. I am not talking—

A. So I couldn't conclude from there.

Q. I am not talking just about those three, Doctor. I am talking about your experience, in general. Would it be fair to say that your view as to D&E, intact D&E reducing the use of anesthesia that is a hypothetical benefit, correct?

A. I think I refer to it earlier as common sensical conclusion, but it is hypothetical in the sense that I do not have peer-reviewed data or method analysis to support it.

Q. You are not aware of any studies showing that intact D&E is quicker, are you?

* * * * *

[615] * * * evidence there to state that that is not a message of dilatation in every case, and I think I testified that I am not sure for both methods, induction or

D&E procedures, that that is true after—between 20 and 24 weeks. And therefore I counsel patients on the possibility of cervical incompetence and subsequent pregnancy.

Q. Now, Doctor, when you employ serial use of osmotic dilators, you put a greater number of dilators into the cervix each time, correct?

A. That's correct.

Q. You have put as many as 20 or 25 dilators into a woman's cervix at one time?

A. That's correct.

Q. Doctor, if one wanted to study whether the cervical dilatation needed for an induced abortion increases the risk of cervical incompetence in pre-term labor, you would have to follow a group of women who had undergone an induced abortion, you would have to follow them into a subsequent pregnancy, correct?

A. That would be—you would have to follow their—into a next pregnancy.

Q. And the larger that group of women the more reliable that study would be?

A. That's true. I think probably impossible to ever conduct a study of that kind.

* * * * *

[634]

A. Secondly, it would not come close. The injury would not come close to the left and right uterine artery.

Q. Doctor, you have given an injection of digoxin to cause fetal demise before an induction abortion at least 30 or 40 times?

A. That's correct.

Q. Now, you wouldn't, of course, do that if you thought the injection was unsafe to the mother?

A. That's true.

Q. Doctor, in the times that you've used digoxin for fetal demise you have never seen any maternal complications from its use?

A. I haven't.

Q. You think that there would rarely be any significant risk to the mother even if the digoxin was accidentally injected in the maternal bloodstream?

A. I think that is correct with the dose we use.

Q. You have always injected digoxin into the amniotic fluid, correct, never into the heart?

A. That's correct.

Q. All right. Doctor, the effectiveness of causing fetal demise in that way is pretty good, isn't it?

A. It's—I do not know in my own experience how the effectiveness is, because I haven't studied it. But I have had at least two failures. I am—I know there is literature out * * *.

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[641]

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[BROEKHUIZEN—REDIRECT]

Q. Okay. I want to clarify, Dr. Broekhuizen, a little bit about your medical practice. If a woman were over 24 weeks pregnant and needed to end her pregnancy due to a maternal health condition, what would you do? How would you treat that situation?

A. Well, I would—after 24 weeks I would have two patients. I would have the unborn and I would have the mother. Different health conditions would have different urgencies for delivery. But even in some of the urgent situations there may be enough time to actually give steroids to the mother to improve the [642] outcome for the neonate. Then one would have to make a decision about what would be the safest method of delivery. And that would again be the cesarean section versus the vaginal delivery, which in that case would be induction method, but a very different induction method with much more physiological utilization of oxytocic drugs. And the point would be to end the pregnancy and undo the risk for the mother. And at the same time optimize the outcome for the neonate.

Q. If you are ending a pregnancy after 24 weeks because of a maternal health condition, do you ever use a destructive act with respect to the fetus?

A. I would never use a destructive act. Only time I would use—would use the word pregnancy's termination" or induction with palliative care being in the context of lethal fetal anomaly.

Q. So to clarify that, you do on occasion end a pregnancy for a lethal fetal anomaly after 24 weeks?

A. That's correct.

Q. And how, in those instances, in your practice, how would you go about doing—just very briefly, how do you end the pregnancy for a lethal fetal anomaly after 24 weeks?

A. Almost exclusively that would be an induction method. Pretend there are these situations where one would have to potentially convert to a D&E procedure or to some elements of a, D&E procedure or where one can anticipate a disproportion [643] during vaginal birth would require a decompressing method as described in the hydrocephaly or in the fetal ascites or nonimmune hydrops earlier today.

Q. But those are all lethal fetal anomalies; is that correct?

A. Those are lethal fetal anomaly. And in my institution, in Froedtert Hospital that would be the rule. All of those patients actually would have had consultations by a neonatologist and by pediatric subspecialties in regards to condition of the fetus and what they could expect as far as when death would occur and what kind of supportive care until death would be provided.

Q. And have you ever done an abortion for a nonlethal fetal anomaly after 24 weeks?

A. Never.

Q. Just specifically with respect to the scenario the patient you talked about who—where the fetus was extremely macrocephalic and she was approximately 28 weeks pregnant and you to use the trocar to reduce the size of the fetal head, was that a lethal fetal anomaly in her instance?

A. Yes, it was.

Q. And was that—what was—what—was there something besides hydrocephaly that made this lethal?

A. It was lethal chromosomal anomaly. I forget. It was 13 or 18. It was one of those.

Q. And does that mean Trisomy 13 or Trisomy 18?

[644]

A. Correct.

* * * * *

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C 03-4872 PJH

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. AND PLANNED PARENTHOOD GOLDEN GATE, PLAINTIFFS

v.

JOHN ASHCROFT, ATTORNEY GENERAL OF THE UNITED STATES, IN HIS OFFICIAL CAPACITY, DEFENDANT

TRANSCRIPT OF TRIAL PROCEEDINGS
Monday, Apr. 5, 2004
Volume 4

BEFORE THE HONORABLE
PHYLLIS J. HAMILTON, JUDGE

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* * * * *

[MITCHELL CREININ, M.D. - DIRECT EXAMINATION]

[646]

* * * * *

Q. Dr. Creinin, I am handing you what is Exhibit 28, which is a copy of your curriculum vitae.

Did you prepare this document?

A. Yes, I did.

Q. Is the information on this true and correct?

A. It is true and correct through January 15th, 2004.

Subsequently, I have been promoted to professor of epidemiology in the Graduate School of Public Health at the University of Pittsburgh, coincident with my promotion to professor in my primary department, and there is a few publications that were in press that are now published, and a few more that are in press, and a few more studies that I have funding for.

Q. And with those exceptions, is this accurate?

A. Yes, it is.

MS. KRASNOFF: We would like to move Exhibit 28, Dr. Creinin's C.V. into evidence.

MS. CLARK: No objection.

THE COURT: All right.

THE CLERK: 28 into evidence.

[647]

(Plaintiffs' Exhibit 28 received in evidence)

BY MS. KRASNOFF:

Q. You can just leave that up there.

Dr. Creinin, where did you do your medical training?

A. I went to a medical school at Northwestern University and did my residency at the University of California San Francisco.

Q. And do you have special training beyond your OB/GYN residency in performing abortions?

A. I did a fellowship in family planning at the University of California San Francisco.

Q. What is a family planning fellow?

A. A fellow is a person who has completed their residency training and then has gone on after residency training to spend time training in both clinical care and research related to abortion and contraceptive services, and other early pregnancy issues that are similar. For example, miscarriage and ectopic pregnancy.

Q. How many family planning fellows are there in the country?

A. There are 12 fellowship sites, and most of the fellowship sites have both a first-year and a second-year fellow. So there are roughly about 24 fellows currently.

Q. How many were there when you were a fellow?

A. One.

Q. Was that yourself or one in addition to you?

[648]

A. There was just myself.

Q. And you stated, I think, you were a fellow at UCSF; is that right?

A. That's right.

Q. Is one of the other fellowships today at Northwestern?

A. Yes, it is.

Q. Who is the director of that?

A. Cassing Hammond.

Q. Is one of those fellowships at Colombia, as well?

A. Yes, it is.

Q. Who directs that fellowship?

A. Carolyn Westhoff.

Q. Is a third one of those fellowships at Oregon Health Sciences University?

A. Yes, it is.

Q. And, if you know, Dr. Creinin, is Joanne Cain the chair of the OB/GYN Department at Oregon Health Sciences University?

A. Yes, she is.

Q. And, also if you know, today are there still fellows at UCSF?

A. Yes, there are.

Q. In your current practice, do you currently supervise a fellow?

A. I have two fellows, a first-year and a second-year fellow.

Q. What kind of training do family planning fellows receive [649] that other obstetrician/gynecologists do not receive in their training?

A. Most of the fellows, including at my center, receive specialized training in research, in getting Master's Degree in either public health or a Master's of Science degree in research. So they learn a lot more about appropriate ways to do research and they also do research as part of their fellowship in the areas that we have discussed.

The clinical training is specialized training in abortion services between four and 24 weeks, including both medical abortions between four and nine weeks and surgical abortion procedures through 24 weeks. And then both research and clinical care in associated areas like ectopic pregnancy and miscarriage, so there is the

balance between contraception and abortion and between research and clinical care.

Q. Are you a board certified obstetrician/gynecologist?

A. Yes, I am.

Q. Where do you currently practice medicine?

A. At the University of Pittsburgh.

Q. Is there a name of a hospital that you work at?

A. Magee Women's Hospital at the University of Pittsburgh.

Q. Please describe your practice at the University of Pittsburgh?

A. I spend about 40 percent of my time performing clinical research, and about 20 percent of my time as an administrator [650] and teacher, and 20 percent of my time in private practice, seeing patients in private practice, and another 20 percent of my time at Planned Parenthood as the Medical and Laboratory Director.

Q. How long have you been at the University of Pittsburgh?

A. Almost 10 years.

Q. And do you perform abortions at the University of Pittsburgh?

A. Yes, I do.

Q. By what methods and what gestational age ranges?

A. I provide medical abortion services up til nine weeks of pregnancy, nine weeks' gestation and surgical abortion services from four to 23 and six-seventh's weeks.

Q. Those are measured by the first day of the women's last menstrual period?

A. Correct or as adjusted by ultrasound to menstrual age.

Q. What methods of surgical abortion do you provide?

A. Suction abortion typically through 14 to 15 weeks and it varies by patient as far as whether in that range of 14 to 15 if the suction abortion is performed or dilation and evacuation is performed, and, again, that's an individual circumstance and beginning at about 14 to 15 weeks through 23 and six-seventh's weeks, then it's a dilation and evacuation procedure.

Q. And you mentioned 23 and six-seventh's. Do you use anything except gestational age to determine the limit to which [651] you perform abortions?

A. No. When looking at the upper limit, I also use ultrasound criteria to look at the biparietal diameter, which is the diameter of the head. And anything more than 56 millimeters in diameter is something that I don't feel I can do routinely by dilation and evacuation.

Q. Fifty-six millimeters of biparietal diameter, can you tell the court how large that is in both inches and centimeters?

A. That's 5.6 centimeters, which is about two and a half, two and a half inches. It's about like that (indicating).

Q. Where do your abortion patients come from?

A. In my private practice, the patients are referred to me by either themselves or by their health care

provider, which is—and most commonly it's their obstetrician/gynecologist.

Q. And what geographic distance do you see patients from?

A. In the Pittsburgh area, there's—there are abortion providers in our city. The vast majority of which also practice at my hospital, although there's not a tremendous number.

Once you get outside of our area, there are no abortion providers. And it's—we have a catchman area of approximately three hours around the Pittsburgh area in travel time, which include women from southern New York, Eastern Ohio, Northern Virginia and all the way into Pennsylvania to approximately the mid-portion of the state.

[652]

Q. And they come from so far away because there are no other providers; is that correct?

A. Correct.

Q. And you mentioned that you are a professor as well. As a professor, do you teach all the methods of abortion that you described that you provide?

A. Yes, I do to students and residents, OB/GYN residents and Internal Medicine residents at times if they want to learn, and then to the fellows also.

Q. I think you mentioned this in updating your curriculum vitae, but is your only faculty appointment in the medical school?

A. No, it's not.

Q. What is your other appointment?

A. I have an appointment at the Department of Epidemiology at the Graduate School of Public Health.

Q. You may have mentioned this a little bit in relation to your fellowship also, but do you have special training that relates to epidemiology?

A. I do. When I was doing my fellowship in family planning, I also did a fellowship at the University of California San Francisco in clinical research. That was a one-year fellowship. And that was what was available at the time. Currently that same type of fellowship is the type of work that earns a Master's of Science degree, just at that time it did [653] not earn that type of degree, but it is that same training.

Q. And you also mentioned you work at Planned Parenthood of Western Pennsylvania. What is your job there?

A. I am the Medical and Laboratory Director at Planned Parenthood Women's Health Services, which is one of the clinics within the Planned Parenthood of Western Pennsylvania system.

Q. And how long have you held that position?

A. Nearly 10 years.

Q. And does Planned Parenthood Women's Health Services provide abortion services?

A. Yes.

Q. To what gestational age?

A. To 18 weeks and zero days.

Q. Do you yourself provide those services?

A. Yes, I do.

Q. By what methods?

A. Medical abortion up til nine weeks' gestation, and surgical abortion between four weeks and 18 weeks, zero days.

Q. And surgical abortion, do the procedures that you do break down by gestational age the same as at the University of Pittsburgh?

A. Correct. 14 to 15 weeks at the breaking point for suction and then 14 to 15 to 18 weeks for dilation and evacuation.

Q. You testified that you teach and perform medical and surgical abortions. Do you have any experience with induction [654] procedures?

A. Yes, I do.

Q. What is that experience?

A. I learned and performed induction abortions when I was a resident in obstetrics and gynecology, also during my fellowship, and then also for the one year when I was on faculty at the University of California San Francisco before I moved to Pittsburgh, and once I moved to Pittsburgh, I no longer performed them.

Q. Do you have any publications related to induction?

A. I do. I have a book chapter in Gynecology and Obstetrics, which is a textbook by, edited by Jack Sciarra, S-c-i-a-r-r-a, and that was published in—that was printed in 1999, and there's an updated version that is coming out that is of the same chapter.

Q. And am I correct you were the author of the chapter in 1999?

A. Correct.

Q. And you are co-author of the chapter that's in press now?

A. Correct.

Q. Is it your understanding that that's a well-regarded textbook in the medical community?

A. Yes, it is.

Q. Other than that textbook, do you have other publications in the field of gynecology?

[655]

A. Yes. I have about 70 publications in peer-reviewed journals, either first authored or co-authored, and then numerous other invited review articles, many in peer-reviewed journals, and book chapters and a couple of books that I am an editor or co-editor of.

Q. What are the major subjects that you've published as an author or co-author?

A. Contraception, abortion, ectopic pregnancy, miscarriage are the bulk of the area. There are some early publications related to multiple pregnancies but primarily the focus is on abortion and contraception.

Q. And you mentioned you also conduct research at the University of Pittsburgh. Can you describe the general areas in which you perform research?

A. The same areas, contraception, abortion, ectopic pregnancy, miscarriage.

Q. Is both your research and your publications, are they reflected on your curriculum vitae?

A. Yes, they are.

Q. So we've talked about a bunch of components of your practice and you gave me a break down, I think, at the beginning, a percentage.

What percent of your practice overall involves seeing patients or patient care?

A. Roughly 90 percent. I have only about 10 percent of time [656] that's purely administrative.

Q. So when you say you are doing research or teaching, that involves patient care as well; isn't that right?

A. Right. It's clinical research with human subjects and the teaching is, although part of it is lectures, the bulk of it is working with residents and students while seeing patients or taking care of patients.

Q. Dr. Creinin, have you ever provided expert testimony before in a case involving a statute that regulates abortion?

A. No, I have not.

Q. And other than your out-of-pocket expenses, are you being compensated for your testimony in this case?

A. No.

MS. KRASNOFF: The plaintiffs would like to move to qualify Dr. Creinin as an expert witness in the area of gynecology and the subspecialty of abortion practice.

THE COURT: All right. Any objection?

MS. CLARK: No objection.

THE COURT: All right. He will be accepted as proffered.

BY MS. KRASNOFF:

Q. Dr. Creinin, you are here today to offer expert opinions about the Partial-Birth Abortion Ban Act of 2003; is that correct?

A. Yes.

[657]

Q. Are you familiar with that act?

A. Yes.

Q. Is it your opinion that that act will ban some of the abortions that you perform?

A. Yes, it will.

Q. I want to talk to you about how you perform—those are by D&E method; is that correct?

A. Yes.

Q. And I would like to talk to you about how you perform D&E abortions and why you think it is that some of those abortions would violate the act. So I want you to walk us step by step how you perform a D&E abortion.

So, let's start with the dilation. What do you do to dilate the cervix for women with a gestational age of 14 weeks LMP or greater?

A. Most commonly between 14 and 18 weeks, I will use a type of dilator called the lamicel, l-a-m-i-c-e-l, which comes in two sizes, 3 millimeters and 5 millimeters.

And it's a firm dilator that when it—when the water is applied to it or it gets moist, actually when it gets moist after it is put in the cervix and it gets moist, it immediately softens. The primary function of the dilator is that it's impregnated with magnesium, and

putting it in the cervix allows the magnesium to locally within the cervix to soften it and it activates enzymes present in the cervix to [658] soften the cervix. Normally the cervix is pretty firm like the end of your nose and the lamicel will cause a cervix over a period of as little as two hours and as much as 24 hours to soften significantly, and the length of time will vary depending upon the gestational age, the history of the patient, other factors that will come into play.

Beyond 18 weeks, then most commonly I will use dilapan, d-i-l-a-p-a-n, depending on the patient's parity and other factors, for example, she's had prior cervical surgery, I may first use lamicel for a couple of hours to soften the cervix to allow me to put an adequate number of dilapan dilators in, and then the dilators will be left in place on average about 24 hours though that may vary depending on when I saw her in the office, when she is scheduled in the operating room, if the operating is delayed a little, so there can be a little variance.

Q. We have heard testimony about osmotic dilators. That's one term people have used. Are lamicel and dilapan osmotic dilators?

A. Yes. Osmotic means absorbs or likes water. So the moment they get moist, they begin to function.

Q. And most of the other testimony has also been about laminaria. Are lamicel and dilapan the same or different from laminaria?

A. They are osmotic dilators like laminaria but they're [659] different. Laminaria is rolled seaweed and will serve the same function as dilapan, but they are just different.

Q. And why do you prefer dilapan or lamicel?

A. Especially the difference is really between the dilapan and the laminaria. I prefer dilapan because I found in my training and in my clinical experience that with dilapan I don't need to put as many dilators in to achieve the same amount of dilation than I would get with laminaria.

And it also makes it a lot easier both for me, as the clinician, and for the patient in that I can usually get in a sufficient number of dilators with one attempt as opposed to with laminaria, we may need multiple times, especially in somebody who has never been pregnant before.

Q. Do you always try to insert the same number of dilapan?

A. No.

Q. For an abortion at say 20 weeks, for example, how many dilapan would you insert?

A. Roughly five, but it, that's the—every patient is little different. So there may be times when I only put in four and feel that in that patient's situation that four will be sufficient. And, again, there is those kinds of factors, but roughly five is what I attempt to put in.

Q. How long do you leave the dilapan in?

A. Roughly 24 hours as stated before.

Q. And what happens to the woman after the dilapan are [660] inserted?

A. She then can go home. We give her very thorough instructions about what to expect after both dilators are placed, as well as what she can expect for after the abortion so that she has all of these instructions in writing with her.

Obviously, long before this, we went over the procedure and the options, et cetera, so these are just instructions now for once we have started the process.

So, for most women, they will experience very mild cramping. They are instructed just to use Advil or Aleve as they would for menstrual cramping. They're instructed to call us if they have severe cramps that require more attention. I would say once or twice a year I get a phone call from a patient saying that she needs something more than the Advil or the Aleve.

Whenever the patients come back at the scheduled time for their surgery, I always discuss with them if they had any problems. And none of my patients have said, "Well, I probably should have called, but I didn't." So, again, it's very rare that there's anything of any significance from the dilator placement. Usually they can go home and do normal activities.

Q. Do you ever require the woman to come back for another insertion of dilapan?

A. In individual circumstances, if I feel I didn't get enough |661| dilapan in her cervix that I would safely be able to perform a procedure, then I have to start again individualizing, and there is not a number of things I could do, the most common thing I would do is either have her come back the next morning, put in more dilapan and do the procedure much later in the day or even then delay the procedure, have her come back, put in more dilapan and do the procedure a day later.

There have been a few instances where based on circumstances related to how far she lived away, or her medical condition, I can't remember the specifics, but there have been a few circumstances where I have also

given her misoprostol vaginally a few hours before the procedure to aid the dilapan, but, again, these are individual circumstances where I have to use my clinical judgment.

Q. Do you routinely use misoprostol?

A. No.

Q. You said that—you testified that you prefer dilapan because you find it is more reliable.

Can you predict when you insert the dilapan exactly how much dilation you are going to be able to get?

A. No.

Q. On average, how much dilation will you try to achieve for an abortion after say 18 weeks?

A. For my patients when I do procedures, after 18 weeks, somewhere between about two to two and a half centimeters is [662] what I require.

And when I remove the dilapan, during the procedure, the first thing I do is assess to see if I feel there's at least a minimum amount, enough that I am content with that I feel I can safely proceed and it's not unusual to have more than that. Again, that is going to vary by patient based on her parity and past medical history, et cetera.

Q. What is her parity?

A. Parity is how many deliveries she has had.

Q. If that happens and you remove the dilators and you find you have more than two, two and a half centimeters, is that a bad outcome?

A. No. That would make the procedure even easier. I am more interested in the minimal amount, not the maximum that I obtain.

I want—I judge the number of dilapan based on making sure I get the minimum amount without putting in so many that I make her uncomfortable or get more dilation than I absolutely need, which I have found at times can cause patients to go into labor or deliver.

And in talking with the patients ahead of time, they are choosing a D&E procedure rather than a labor induction because they don't want to go through labor. So, I am trying to balance all of those factors and deciding how many dilapan I insert for that individual patient.

[663]

Q. Now, I want you to go through what you do step by step after the cervix is adequately dilated. If it helps you at any point, we have these diagrams for you to refer to.

A. Beyond 18 weeks, I only perform those procedures in the operating room at Magee Women's Hospital. I don't do those procedures at Planned Parenthood.

Most commonly the patient gets a—has conscious or deep sedation by an anesthetist or anesthesiologist—I should is say anesthesiologist because it can be an anesthetist working with the anesthesiologist. In rare circumstances, the patient will receive a spinal anesthetic or even more rare general anesthetic but this is all decided ahead of time in consultation with the patient and the anesthesiologist.

Once we are in the operating room and she's placed with her legs up in stirrups in a lithotomy position and she has received her anesthetic, I will put in a speculum and remove the dilators.

I will then use a sterile cleansing solution, most commonly iodine, to clean the cervix and vagina, and the area right around the introitus. And then I will give a local anesthetic which also contains a small amount of vasopressin, which is a medicine to help constrict the blood vessels in the cervix, in the lower portion of the uterus.

I will then use a grasping instrument to hold on to the cervix, which is called a tenaculum, and then I will pull [664] on the tenaculum—actually, I will pull on the tenaculum to both stabilize the cervix, I can hold on to it, but I also want to change the position of the uterus.

Is it okay if I get up?

THE COURT: Sure.

THE WITNESS: So this diagram is kind of difficult because the vagina really isn't this long and the uterus is bigger because it has a pregnancy in it, but the uterus does sit at an angle to the vagina. And actually in an enlarged uterus at 18 weeks, the sacrum, which is here, the sacropromontory, the uterus has grown to here (indicating) where it's always going to be tipped up because it hits this bone and moved up.

So it is important with the tenaculum to pull down on the cervix to straighten that angle more so that the instruments when they pass into the uterus are going straight into the uterus as opposed to trying to maneuver this angle. That's all to try and reduce the risk of perforation.

Now, the speculum, which has blades—actually, if you imagine this straightened out, that will fit into the, what is called the fornices. And actually at times, almost prevent the uterus from coming down, so it's not infrequent that I will actually even remove the speculum and do the procedure without a speculum or use a weighted speculum, which is an instrument that just kind of hangs on the perineum.

[665]

THE COURT: Other doctors have testified as to bringing the cervix down almost to the introitus.

How does that happen if there is a speculum inside?

THE WITNESS: The speculum actually almost gets pushed out. So, depending on the woman's parity, how many deliveries she has had, the more para she is, the more it comes down. That's why in those situations you need to either sit there with the speculum halfway out or remove it and use either a weighted speculum or no speculum.

The cervix very commonly ends up very close to the opening, if not all the way down at the opening. And, again, you have to judge individually what happens. So that's what the tenaculum does. And then—

BY MS. KRASNOFF:

Q. What do you do to evacuate the contents of the uterus?

A. The first step I take is, again, most commonly in every patient I have to sometimes do variations based on whatever is going on.

Most commonly the next step would be to rupture the amniotic sac using a cannula. Obviously if she has already had ruptured membranes, I wouldn't do that. Most commonly I would then take an 11 millimeter cannula and insert that in the cervical opening while under direct visualization with ultrasound, and use that with the suction on it to break the [666] amniotic sac to drain the amniotic fluid so all of the fluid is removed first.

In situations where I can't with the cannula break the amniotic sac, I will actually, with a small ring forceps, just grab the sac and pull on it to break the sac. So then the fluid can drain, I can then put the cannula in and drain all of the amniotic fluid. It is important to drain the fluid first to—when the uterus decompresses, in other words, remove the fluid, the uterus, the first thing it will do is to contract and that brings all of the fetal parts down into the lower part of the uterus because my goal is just to instrument in the lower part of the uterus. I don't want to reach up high because that's how you can cause uterine injury.

So, after I drain the amniotic fluid, I'll then most commonly use bierer forceps, that's b-i-e-r-e-r, although for gestational ages that are closer to 18 weeks or at times where I may not have—where I've put in, the simplest way to say it is in gestations closer to 18 weeks sometimes the dilation is adequate enough for sopher forceps, but not bierers. They are very similar, just the size is different. Sophers are about 1.5 to 1.6 centimeters in diameter and bierer are most commonly about 1.9 centimeters. So either one can be used. Obviously, the more advanced the gestation, the more dilation there is, and the bigger forceps would be used.

Using the forceps, then I would open them, insert [667] them through the cervix opening. As I get close to the—as I begin to enter the uterus, so that I can open the instrument as widely as possible in the lower uterine segment, and it is not very wide, you are limited by the uterus itself, but just staying in the lower uterine segment, if possible, to grasp whatever is there. That's the basic concept, but then you have to use all—because all of this is done under ultrasound guidance, my goal is really to grab a lower extremity or some other portion other than the head. So what I am going to do is vary by the fetal position.

If it is head first, it's very, very, very difficult to try and grasp the head as the very first thing. So, with every D&E, the way I have been taught, the way I have always done it, the way I have always taught it is to try and grab a lower limb to convert the position to breech and then proceed with the evacuation. If it's already breech, or if it's transverse, that's easier to grab a lower extremity.

After grabbing the lower extremity, I am going to pull the pregnancy or pull whatever part I have grasped through the open cervix until there is resistance from the lower uterine segment and the internal os. My goal is to try and remove the fetus as intact as possible. The fewer passes, the safer it is for the woman.

So, as I pull down, the uterus is going to tell me how far I can go just by the resistance I get. So when I meet [668] resistance, I will continue to pull, and it's the pressure of the fetus against the lower uterine segment that actually results in dismemberment of the fetus. And where that is going to happen on the fetus will vary from patient to patient.

As the fetus—tissue that I am holding on to gets—is in—

Q. I want to break it down. You just told us a lot of things you do.

A. I am just proceeding through.

Q. That's okay. I am going to stop you and ask you some questions about how much—what you've told us so far.

A. Okay.

Q. I just want to make it clear, you are always doing post-18 week procedures under ultrasound guidance; is that correct?

A. Correct. I use ultrasound guidance for all of my procedures where any instruments are placed in the uterus other than a suction cannula.

Q. Can you explain why it is that you think it is beneficial to grasp a lower extremity regardless of the presentation of the fetus?

A. As I said earlier, it's incredibly difficult to grasp the head first. The head, until about 34 weeks of pregnancy, is much larger than any other part of the fetus.

So, if I am trying to grasp the head and there's other small parts behind it, it just becomes a physical [669] difficulty in grasping the head.

So, again, from the way I was taught from the very beginning, and it is almost common sense if you think about it, you convert the fetus to breech so that's where especially using ultrasound guidance, the safety comes in because I am going to watch my instrument, guide it to an extremity, so that when I teach the

procedure or I ever talk about it, this is a standard way of doing dilation and evacuation.

Q. So is it sometimes the case that the fetus is presenting in a head first or vertex presentation and you would grasp a lower extremity and rotate the fetus so that it is feet first?

A. Virtually all the time. It is on rare circumstances that I get the head first and it's usually only because the head is so applied to the cervix I can't really get passed it to try and get a lower extremity. And I can think of once or twice in my entire career that I can think that I have done that.

Q. This is because you think it is safer for the woman to grasp the lower extremities first; is that correct?

A. Yes, that's the way the procedure is done.

Q. Are you aware, Dr. Creinin, that one of the congressional findings of the act that's at issue in this case states that converting the fetus to a breech presentation increases certain risks and some of the risks they name are uterine rupture, abruption and amniotic fluid embolus.

Do you agree with that finding?

[670]

A. Not at all.

Q. I want to go through each of those risks and have you explain what they are and why you think it is that that finding is incorrect.

A. Okay.

Q. What is abruption?

A. Abruption is premature separation of the placenta from the uterus. And that wouldn't apply in the situation because my goal is to remove the placenta as part of the procedure.

And sometimes it comes out as one of the first things I remove, sometimes it comes out in the middle of the procedure, I am going to grasp whatever I am grasping, and when I get a hold of it, I am going to remove it.

So those findings apply to cases where a delivery is being done with the intent of a live fetus being born, but separating the placenta from the uterus is an innate part of the D&E and has no implication here at all.

THE COURT: Excuse me. In a live birth situation, you don't want the placenta to come out even in part before the baby comes out.

THE WITNESS: Exactly because the fetus is getting its oxygen and nutrients through the placenta. And an example would be a woman at 30 weeks of pregnancy starts to have bleeding because the placenta separates prematurely. She can not only lose a lot of blood, but the baby could die. So that [671] that would be a potentially catastrophic situation.

Or there are maneuvers done at term, for instance, internal podalic version, which you have heard about, at term and the placenta separated and the fetus was unable to be removed right away, but the fetus would be stuck in the uterus with the placenta separated and no way to get oxygen. So at term, that would be important, but as part of an abortion procedure, it's completely irrelevant.

* * * * *

[673]

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Q. Move on to amniotic fluid embolus. Dr. Creinin, what is amniotic fluid embolus?

A. That's when the amniotic fluid enters the woman's circulation usually through a sinus, which is a large opening, in the lining of the uterus that would be part of the way the blood was getting to the placenta from the woman.

So, again, at a D&E procedure, since the first part is to remove the amniotic fluid, that's a moot point since it's already been removed as part of the procedure.

Q. So, just to be clear, it's your opinion that turning the fetus in utero would breech the presentation in a D&E doesn't cause any greater risk of amniotic fluid embolus than if you do not do that conversion?

A. First of all, amniotic fluid embolus is so incredibly rare, it would be hard to show any increase risk at this gestational age.

THE COURT: Can you describe what it is again?

THE WITNESS: I am sorry. The amniotic fluid, when it gets into the woman's bloodstream, so it gets in through some openings in the uterus. So if it gets into her bloodstream, it will first go up to the heart and then into the [674] lungs. And in the lungs, I apologize, I didn't say this earlier, in the lungs it causes an incredibly fast tissue reaction that will cause her to quickly not be able to exchange air across her lungs. She will become hypoxic, which means has low oxygen, go into a respiratory arrest and then cardiac arrest. It can lead to—the heart has its own little brain that makes it

pump or it makes it beat at certain rates so the electrical system of the heart can still be working, but the heart muscle itself doesn't respond to it at all. So if an EKG monitor was on the woman, it would look like everything is normal, but her heart isn't pumping. These are things that can occur with amniotic fluid embolus.

THE COURT: Is it fair to assume then, if there was such an occurrence, that that would necessarily follow from a perforation of the wall of the uterus? Is there any other way for it to get—

THE WITNESS: Not really. It's just from the openings that are there, where most commonly where the placenta is attached. So, it's not from a hole in the uterus, it could just be that when the placenta detaches and some of those openings are exposed that amniotic fluid could get in.

Again, with D&E procedures, the amniotic fluid is primarily removed first before any of those things occur.

THE COURT: Okay.

THE WITNESS: It's an incredibly rare occurrence at [675] term let alone even at this gestational age.

THE COURT: Thank you.

BY MS. KRASNOFF:

Q. What would be the difference of why that would occur at term versus in a D&E? You've testified to this, but just to make it clear.

A. At term, the amniotic fluid is, number one, still there, and then even in a woman with ruptured

membranes, the amniotic fluid primarily comes from the fetal urine, so the fetus is still peeing inside. And also as a woman going through delivery, if you can imagine the head going through the cervix at term, it wedges in, so as it pees inside, the fluid is going to rebuild up inside the uterus. So that if abruption was to occur during delivering, there still would be fluid there. Whereas, again, during an abortion at this point in pregnancy, it is relatively a moot point. It is an incredibly rare occurrence to start with.

MS. CLARK: Your honor, I just want to make my objection. I agree with counsel that on page 163 the question was: In doing that, was there any concern by reaching around the part with forceps—

THE COURT: Slow down.

MS. CLARK: I'm sorry.

I am rereading from the deposition page 163, lines 9 through 14. And I think the testimony of converting the breech [676] at term versus converting to a breech position during an abortion, I think that goes beyond the scope of his deposition testimony.

THE COURT: Well, counsel, I will allow it at this time. You withdrew your objection previously. It seemed the appropriate thing to do is given the excerpt, perhaps we will move on to some another subject, I am not going to strike his testimony.

MS. KRASNOFF: A few more questions about turning the fetus, then I will be moving right along.

BY MS. KRASNOFF:

Q. Does turning the fetus increase the risk of rupture or trauma to the uterus?

A. Not at all. That's a part of D&E procedures. So all of the data that has ever been published includes that information.

And the act itself potentially could cause uterine rupture, but any procedure, any part of the procedure, just like labor induction, just like anything else, so it's more of a relative term. Could it increase at more than something else? No. It's just that the act itself can cause rupture of the uterus just like any other part of the D&E could.

Q. Just to be clear, by "act" you mean little "a" act of turning the fetus, you're not talking about the act as we've talked about in this case?

[677]

A. I'm sorry, the action.

Q. I just wanted to be clear.

My final question on this topic, is that the congressional findings state that a leading obstetrics textbook says there are few, if any, indications for turning the fetus in utero other than for delivering of the second twin. Are you familiar with that?

A. Yes, I am.

Q. Is that relevant here?

A. No. Again, that—

MS. CLARK: Objection on the basis of who's to say what is relevant or not relevant. I think that calls for a legal conclusion.

THE COURT: Sustained. Rephrase.

BY MS. KRASNOFF:

Q. Do you think that there—that that statement that there are indications in a D&E for turning the fetus in utero?

A. I don't agree with what was stated in the congressional findings that—I am confused.

I don't agree with the congressional findings. Is that sufficient?

Q. The congressional findings say there are few, if any, indications. But you've testified that you do turn it. So, I am asking if you believe there are indications—

A. Doing a D&E is a indication for turning it.

[678]

Q. And is that—are you familiar with that textbook?

A. Yes, I am.

Q. Is that speaking about delivery at term?

A. Yes, it is.

Q. So, moving along, once you've located and grasped the lower extremities and turn the fetus if you need to, what do you do next?

A. Pull with the instrument that I am using to remove the fetus with the attempt to remove the fetus in as few passes as possible. So until I meet resistance from the lower uterine segment, I will continue to pull.

Q. Why—

A. And once I meet resistance, I will then, while holding on to the fetus—minimal rotation, but just kind of try and ease those parts through the cervix to allow whatever's meeting resistance to try and slowly get through the cervix.

The fetus will either continue to come or will begin to break apart. It will break apart wherever or whatever it is. It may be in the middle of the leg, it may be at the abdomen, it may be at the chest, just depending on the dilation and the size of the fetus, et cetera, just on that individual case.

Q. Does it ever happen that you are able to extract the fetus intact or relatively intact up beyond the navel?

A. Yes. The level of the umbilicus, yes.

[679]

Q. Can you explain what that is?

A. There actually is no navel in a fetus. You and I have a navel because our umbilical cord was gone. The fetus has an umbilicus, but no navel because it still has the umbilical cord attached.

Q. At that point when the fetus has been removed, we are going to use "past the navel" because the act uses that.

A. Correct.

Q. You understand—

A. I understand the intent, correct.

Q. You understand it to be the umbilicus?

A. Yes.

Q. Would the fetus still have a heart beat?

A. Yes.

Q. Then what would you do next?

A. I would reach into the lower uterine segment and grasp whatever part is there and then continue to remove the fetus.

If, once—usually, if the fetus has been dismembered, the last part is the calvarium, the head. At that point, I will grasp the head and crush it like other parts of the fetus and remove that.

I will then, if the placenta hasn't been removed, reach up and remove the placenta. I'll then, using the suction cannula, suction the lining of the uterus to ensure that the lining that was there as part of the pregnancy has been removed [680] and any parts of the placenta that still may be present are removed.

I will then take a really a blunt curette, dull curette to feel the lining of the uterus, again, still under ultrasound guidance to ensure that it feels like everything has been removed to me, and then look and make sure that the bleeding is at a level that I would expect it to be, remove the tenaculum from the cervix, make sure there's no cervical tears or lacerations. If there is a speculum, I would remove it at that point and then the procedure is completed.

Q. Does it ever happen that in grasping the fetus you're able to remove the fetus intact or relatively intact all the way up to the calvarium?

A. Yes, on occasion.

Q. If that happens, would you do anything differently to complete the procedure?

A. If the fetus is intact up to the calvarium, there's two things I could do.

One would be to continue to pull, and usually it comes apart at the level of the neck, or I can insert,

what I would I have done is insert scissors through that part of the head under direct visualization, inserted the 11-millimeter cannula that I used before and drain the brain tissue and then the head comes through the opening.

I have done that on a few occasions. Most commonly [681] it's the first.

Q. The first meaning?

A. Just that it separates, the body separates from the head.

Q. And back to the example where it is removed intact or relatively intact up to the navel, how frequently, in your practice, does that happen?

A. At least once a month.

Q. Does it ever happen that you've disarticulated some part of the fetus, but then on another pass with the instruments you are able to remove the fetus passed the umbilicus?

A. Yes. Sometimes I've made an initial grasping, have a foot or portion of the lower extremity come off, and then with the second grasp, it would still come out past the level of the umbilicus. So it still would be mostly intact.

Q. Could it still have a heartbeat at that time?

A. Yes.

Q. And what would you do next if that had happened?

A. I'd still continue in the same methodology because my objective is to remove the pregnancy from the uterus.

Q. And when you begin the procedure, can you anticipate how much of the fetus you are going to be able to extract without disarticulation?

A. Not at all. It is going to vary from woman to woman based on her parity and how the cervix responded to the dilators. My main objective is the minimal amount.

[682]

Q. Would you ever take any steps to make sure that it's not removed intact?

A. Can you—intact up to the level of the umbilicus you mean?

Q. Yes.

A. No.

Q. Do you think there is anything safe about removing the fetus intact up to the umbilicus or to the calvarium?

A. The fewer passes, I feel the safer it is. Yes, I feel it's safe.

Q. I actually asked if it was unsafe.

A. I am sorry, I thought you said safe. Do I think it is unsafe? No.

Q. You mentioned that sometimes you use scissors to instrument in the base of the skull.

Is there anything that is unsafe about the insertion of scissors into the base of the calvarium?

A. When I do it for my patients, no, it is under direct visualization.

Q. Have you ever had an injury or a complication from an abortion where the fetus was removed intact up to the calvarium?

A. No.

Q. And you said—we talked about the procedure is complete. How long after you completed the procedure before the woman can [683] go home?

A. On average it's about two hours.

Q. I want to put up on the easel—

MS. KRASNOFF: If I may I approach, Your Honor?

THE COURT: Yes.

BY MS. KRASNOFF:

Q. —copy of the operative portion of the Act. If you would read that, Dr. Creinin, not out loud, to yourself is fine.

We talked at some length about the D&E abortions that you performed. I would like you to explain to the Court why it is that you think some of the D&E's that you performed would violate this definition of partial-birth abortion?

A. Well, primarily it's in the case of a breech presentation, that any part of the fetal trunk past the navel is outside of the body of the mother. As I was alluding to earlier with the other diagram, it is very common for the cervix to be down far in the vagina so that as the fetus is being removed through the cervix, the fetus would be, have the fetal trunk past the navel outside of the body of the mother relatively commonly.

So that right there would violate the Act because the purpose of my act is to kill the partially-delivered living

fetus because that's the objective of the abortion. And anything I would do once it's past the level of the navel, would be an overt act because I would be doing something [684] because the goal of my procedure is to perform an abortion.

Q. Would those be lethal acts to the fetus?

A. It would be lethal to the fetus.

Q. And would this definition cover the situation you discussed where you actually already disarticulated part of the fetus but then are able to remove past the navel?

A. Well, it doesn't state that it has to be completely intact, so that I think of a foot is removed and everything else is intact, I would take it to meaning okay. Otherwise then we—yes. So I would take it as that way.

Q. What is a spontaneous miscarriage?

A. A spontaneous miscarriage is when a woman will begin to pass their pregnancy tissue without any action by an outside person. So without treatment of some kind to cause it to pass.

Q. Do you treat patients that present in the midst of a spontaneous miscarriage or aa pre-term labor between 16 and 24 weeks?

A. Yes.

Q. Do you think that you could ever violate the Act based on what you do in that session?

A. Patients would be referred to me in that situation sometimes acutely for a D&E if the—if their obstetrician or fetal medicine consult has talked to them about what their options are. That's when I see those

patients. And because those patients commonly have advanced dilation then, yes, I [685] would violate the Act.

Q. And is it correct that when you see and treat those patients, you are completing the removal of the pregnancy by D&E?

A. Correct.

Q. Before we talked about this definition, you said that you don't routinely take extra steps to ensure that you have adequate dilation in order to be able to remove the fetus intact up to the calvarium.

Are there any circumstances in which you would take extra steps to make sure that you could do that?

A. I was presented with a patient where I wanted to avoid dismemberment as much as possible and a normal part of the procedure if the—when the fetus does pull apart with the D&E is that there are boney fragments. That's just part of it.

And the goal, one of the goals of putting of the instrument is not only to grasp the fetal parts, but to be around the fetal parts to protect the lower uterine segment and the cervix as you are pulling those parts through the canal, so it is the safest as possible for the woman.

Those boney fragments though can tear the lower uterine segment of the cervix slightly not through the cervix or through the lower uterine segment, but tear as they are dragging through. That's partly why we include vasopressin, that medicine that constrict the blood vessels in the cervical [686] anesthetic.

For a woman who is anticoagulated, which means her blood was thinned so that she wouldn't clot, and she had to stay on that anticoagulation—living in Pittsburgh we see a lot of women with liver failure, the liver makes the products that are necessary for the blood to clot. So that if she was anticoagulated for that reason, then I would not want boney fragments to be there, and I would want to remove the fetus as intact as possible.

* * * * *

[689]

BY MS. KRASNOFF:

Q. Actually, based on your experience, you mentioned the liver transplant as well. Is there another case, an actual patient that comes to mind there?

A. There was—I have had a patient who had fetal demise where the situation arose, and in that situation, I would have chosen to do an intact removal if we got to that point, but she passed away.

Q. And can you explain why in that case intact removal would have been preferable?

A. Because her liver had completely failed, and she had no way of clotting.

Q. Would it have been safe to do an induction in that case?

A. No, that would have killed her without a doubt in trying to get her through the induction.

You have—inductions is a very prolonged process, and there is going to be bleeding throughout the induction. So as the fetus begins to pass through the birth canal or the placenta begins to separate, here is a

woman who can't clot at all. I would want to do a procedure on her under very controlled circumstance than to make the procedure go quickly. You have a period of bleeding, be a short time, to have support people around. There is a benefit of being in an operating room where it's like an intensive care unit, in a sense. You have the ability to handle things acutely. [690] So a procedure in that situation would be preferable. And these are situations also where the maternal fetal medicine specialists in our department are part of the consulting team, and the majority of the patients like this that have severe, actually almost all of the patients with severe medical conditions are referred to me by the maternal fetal medicine specialists in our department.

Q. We are going to switch topics a little bit.

I know you were looking at the clock, your honor. Do you want to go to four?

THE COURT: I am assuming you will be finished by four with the direct?

MS. KRASNOFF: With the direct? Yes, you're incorrect.

THE COURT: We will go to four.

MS. KRASNOFF: Close though.

BY MS. KRASNOFF:

Q. We are going to switch and talk about cervical incompetence. What is cervical incompetence?

A. Cervical incompetence is a weakening of the structure of the cervix that would not allow it to stay closed with pressure from a growing pregnancy.

So, the cervix is actually about 80 percent connective tissue and 20 percent muscle, whereas the uterus is [691] all muscle, or virtually all muscle. So that connective tissue, also called ground substance, and it's very strong tissue. So, the inability of that strong tissue to just maintain its structure when there is a lot of pressure from a growing pregnancy, cervical incompetence, and it results in painless dilation of the cervix.

Q. Are you aware, Dr. Creinin, that the findings of the Partial-Birth Abortion Ban Act state that the amount of dilation needed in order to be able to remove a fetus intact up to the calvarium increases the risk of cervical incompetence?

A. Yes, I am.

Q. Do you agree with that finding?

A. No, I don't.

Q. Can you explain why not?

A. Well, first, there is a physiologic basis. Labor is a process where the cervix dilates to 10 centimeters, if you take a woman at term. It's usually 10 centimeters over a relatively short period of time.

Most women go through labor would hope it would be a very short period of time, but in a D&E procedure, we are talking about slow dilation to two to two and a half centimeters over a period of 24 hours. So, it doesn't even make physiologic sense that it would cause more damage to a cervix to have a slower dilation in a longer period of time or slow dilation to a lesser amount compared to a greater dilation [692] in a shorter period of time. So, there is no physiologic basis for it.

Then the literature that is available, when you look at the literature, there are a couple of studies that are—that report on a few pregnancies, relatively few, 60 to a hundred or so, of women who had procedures and then had subsequent pregnancies. And the rates, there was no increased rate of pre-term birth or pre-term delivery or cervical incompetence in those women.

Now, those studies aren't large enough to make conclusions, but if you take those studies that are available along with the common sense physiology of what's going on, I think there is no way you could determine that there would be cervical incompetence. There is definitely no studies to say it does, and it doesn't make any sense to say that it would happen. And you would—because the common sense part of it is that it wouldn't happen, you would need really large studies to prove that it does.

MS. KRASNOFF: May I approach, your honor?

THE COURT: Yes.

BY MS. KRASNOFF:

Q. Exhibit 17, the Kalish article. Dr. Creinin, I handed you what has been marked as Exhibit 17, which is an article by Doctors Kalish, Chasen and several others, which is entitled "Impact of Mid-Trimester [693] Dilation and Evacuation on Subsequent Pregnancy Outcome." This article was published in the American Journal of Obstetrics and Gynecology, volume 187 in October of 2002.

Are you familiar with that article, Dr. Creinin?

A. Yes, I am.

Q. Is that one of the studies you talked about that use relatively small numbers of women?

A. Yes, it is.

Q. Can you tell the court, please, about that study?

A. In this study it was a retrospective review, which means they looked back on charts of 600 women who had D&E procedures, and 96 of these women had subsequent pregnancies. So they looked at those 96 pregnancies, and—to see what the outcomes were, and specifically related as cervical incompetence.

There were five women—I am sorry, there were 10 deliveries that were before 37 weeks, five of which were obstetric or maternal indications for them. There were five women who had prophylactic cercloges, which are stitches in the cervix to keep them closed. Those five—four of those women had a history of cervical incompetence that preceded the D&E that they had previously, and one other person had DES exposure, and that's why her doctors chose to put in the cerclage. That's also an increase risk factor for cervical incompetence.

So none of those patients had evidence of cervical [694] incompetence. And there were no patients who received any emergency cerclages meaning that experienced cervical incompetence, so what they found in these 96 women is that there was no evidence of cervical incompetence.

As I said, that is a small study, but at least it gives you some idea that it fits in the theoretical understanding of what you would expect physiologically.

Q. Just to be fair, what were the gestational ages of the women involved in this study?

A. Fourteen to 24 weeks.

Q. What kind of abortion procedures had they had?

A. Dilation and evacuation.

Q. Is it your understanding that they received osmotic dilation prior to the procedure?

A. For the dilation and evacuation?

Q. Yes.

A. Yes, it is.

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[700]

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Q. Yesterday you gave some testimony. I just wanted to clarify one thing about that.

You stated that you believe there may be liver patients for whom an intact removal or an attempt to remove the fetus intact may be preferable. Is there a reason why you believe in your practice you would see those sort of patients?

A. Well, patients with liver transplants or liver problems. At the University of Pittsburgh where I practice is pretty much the liver transplant capital of the world.

It is where things pretty much were developed and started, and so they get patients who come from all over the world to get their liver transplants and other transplants.

Q. And when we broke yesterday we were talking about cervical incompetence and about—we had just finished discussing the study by Drs. Kalish and Chasen and others about D&E abortions and whether they lead to cervical incompetence.

Are you familiar with other studies that relate [701] specifically to D&E abortions and that issue?

A. There is one other study by Schneider, which is a series similar to the Kalish study, which just comments on follow-up with patients after D&E, showing that—I believe it was around 60 odd patients.

MS. KRASNOFF: If I may, approach Your Honor.

THE COURT: Yes.

MS. KRASNOFF: This is Learned Treatise Four.

BY MS. KRASNOFF:

Q. Dr. Creinin, this is an article by Dr. Schneider and several others, entitled:

"Abortion at 18 to 22 Weeks by Laminaria Dilation and Evacuation," published in volume 88 of Obstetrics and Gynecology in September, 1996.

Is this the study you were referring to?

A. Yes.

Q. Can you explain that study briefly and its conclusions?

A. This was a case series of 171 dilation and evacuation abortions. And in the findings, in the results at the time of the report there were 61 women who were pregnant following the D&E procedure, and none of those women had cervical incompetence. And the authors specifically comment on it on the last page of the article.

Q. And those women had abortions by the D&E method; is that correct?

[702]

A. Yes, it is.

Q. And what were the gestational ages of the women when they had the abortion?

A. Eighteen to 22 weeks.

Q. Now, we have talked about these two case series which demonstrate or conclude that there's no increase incidences of cervical incompetence or at least suggest that; is that correct?

A. Yes.

Q. Do you know of any date that suggests that osmotic dilation prior to a D&E does lead to cervical incompetence?

A. No.

Q. At the beginning of your testimony yesterday, you testified that you have conducted gynecologic research yourself; is that correct?

A. Yes.

Q. What is a prospective randomized trial?

A. That's a study where there are two or more groups assigned to a specific treatment or intervention, and that assignment is random, either by like similar to flipping a coin, and most commonly today we use computer-generated tables to provide the randomization. And the treatment or the intervention is one in which the study participant and the people performing the study have no choice or say on what treatment or intervention they [703] get.

And then, the participants are followed prospectively, meaning from the time of the intervention

forward, to see what happens from the intervention or treatment.

Q. And have you yourself ever designed and conducted prospective randomized trials?

A. Yes.

Q. How many have you been the principal investigator for?

A. Eight for which I have been the person who designed, carried out, not just being a principal investigator at my center for a study that is going on in a lot of other centers, but actually eight that I have been in charge of completely.

Q. In addition to the eight that you have been in charge of, have you been involved in others?

A. Yes.

Q. Do you know approximately how many?

A. More than 20.

Q. And have you ever designed and conducted, where you were the principal investigator, a prospective randomized trial specifically related to abortion methods?

A. Yes.

Q. And can you describe that study, please?

A. That was a study looking at early abortion methods, medical abortion versus surgical abortion. And this was a study in [704] women up to seven weeks of pregnancy, so it was very early. But the study was looking at randomizing women to one of the two treatments. And the criteria for enrollment in the study was

that women had to have no preference for which method they wanted.

They, the women, went through counseling first about the different options. And then, if they truly felt they had no preference, and they met the other entry criteria they could be enrolled in the study.

Q. And how many women were you trying to enroll in the study?

A. The sample size estimates—sample size estimates for the outcomes I was looking at were about a hundred women total.

Q. What was your experience in trying to do that?

A. After two years we stopped the study early because we could only enroll 50 women after two years. We interviewed or had not interviewed, but had approximately a thousand women contact us about the study. And after reviewing the options with them and the different options for abortion, only 50 after two years felt that they truly had no preference.

Q. And you spoke to all or someone spoke with all thousand of those women?

A. Correct.

Q. Based on your experience with this study, do you have an opinion about whether it would be feasible to conduct a prospective randomized trial about abortion methods after 16 [705] weeks of gestation?

A. Yes, I do.

Q. And what is that opinion?

A. If I go back to the study a little bit, even for those 50 women, once they enrolled in the study, I then did further very sophisticated testing to see if they

truly had a preference. And actually 35 of the 50 really did have a preference once you could figure it out.

So there were truly only 15 women who had no real preference as to which method they preferred out of a thousand over two years. And this is in women up to seven weeks. And there is a much larger pool of women available in the U.S. when you look at the number of abortions done in the U.S. and at what gestational ages.

So when you start to look, then, at later gestational ages, the ones we are talking about after 16 weeks, there is relatively significantly fewer women who are having abortions at that time.

So to have a prospective randomized trial would be unfeasible, unreasonable and impossible to do.

Q. And if you were trying to prove safety, specifically, of various methods of abortion after 16 weeks, is there a reason that that would be difficult, as well?

A. All the labor induction, D&E, they are all very safe methods. And we have heard there is a lot that goes into a [706] women's decision as to which method she prefers. And in an individual circumstance, both personally for her, as well as medically. And when you start to look at outcomes, when the outcomes you are looking at are very rare or they don't occur very frequently, if you are looking at serious morbidities—with any of these methods you are looking at things that are 1 to 2 percent at the greatest.

So for methods that are very safe, very effective, in general to try and prove a difference or prove that one is better than another for all comers, for all people would be impossible. The sample sizes would be huge.

I have done some calculations, can I—

Q. Sure.

A. I am happy to share this.

THE COURT: Has this been made—

MR. SIMPSON: This has not.

THE WITNESS: I did this on my computer a couple days ago, and I am happy to share it. But it's just that if you had an outcome that was 1 percent for one group and one-half of one percent for another group that you were trying to say there is a difference those outcomes, you would need over 5,000 women per group to prove that was statistically significantly different.

So, if you were at 2 percent versus 1 percent, you are still over 2500 women per group. And then, to get people [707] who could do research and to get women who then were interested and willing to be randomized, it is just a completely unfeasible study.

There is another study we just finished that was funded by the NIH, where it was looking at miscarriage and the treatment of early miscarriage. And women were randomized to medical or surgical treatment. And there were four very large, well-respected centers that were awarded the contract by the NIH to do the study with the goal that we would enroll 800 women over about a year-and-a-half between the four centers.

And in over two years the four centers could only get a little over 600 women. And we recalculated our sample size needs and felt that was enough. But that was in early miscarriage.

So to get women to say they are willing to be randomized between surgical and medical method

because they have preferences and there are differences for them as individuals, is, again, unfeasible at the gestational ages we are talking about for D&E versus labor induction.

BY MS. KRASNOFF:

Q. And other than your own experiences, do you rely on any other studies in reaching the conclusion that a study of procedures after 16 weeks would be extremely difficult?

A. There was a study just published by David Grimes from North Carolina that looked at the feasibility of this issue and—

[708]

Q. Would it help if I showed it to you?

A. Yes.

MS. KRASNOFF: If I may approach, I would also like to share his notes with counsel.

THE COURT: If you would. And what is it you are referring to?

MS. KRASNOFF: This is Learned Treatise 11.

BY MS. KRASNOFF:

Q. Dr. Creinin, that is a study by Dr. Grimes at the University of North Carolina and others entitled:

> "Mifepristone and Misoprostol Versus Dilation and Evacuation for Midtrimester Abortion: A Pilot Randomised, Controlled Trial."

This was published in the British Journal of Obstetrics and Gynecology just this February, 2004, in volume 111.

Is this the article you are referring to?

A. Yes.

Q. What was Dr. Grimes comparing?

A. The primary objective of the study was to assess the feasibility of randomizing U.S. women to these two methods of abortion. So labor induction process versus dilation and evacuation.

Q. Okay.

A. And the goal was in assessing the feasibility to —they [709] calculated the sample size of 60 women that they would need to compare the two from a feasibility standpoint, and they also established that if they could not enroll at least 20 women in twelve months, or 40 women in 24 months, they would consider it unfeasible and stop the study.

Q. What was their experience?

A. In twelve months, they could only enroll 18 women, because the majority had a preference for what they wanted to have as far as their method of abortion.

Q. What was the gestational age range that Dr. Grimes was looking at?

A. These were women, I believe, up to 20 weeks, but I need to—14 to 19 weeks. So between 14 and 20 weeks.

Q. And why does Dr. Grimes' experience support your view about the feasibility of randomized trials after 16 weeks?

A. If you were going to do studies of this nature you would need well-respected researchers and well-respected institutions that know how to perform research appropriately. And the institution where Dr. Grimes is

and Dr. Grimes himself is an incredibly well-respected mentor, researcher, teacher.

And I can think of nobody who would be a greater example of how to construct such a study. And if they couldn't find it feasible there, I wouldn't—and "feasible" meaning 20 people in a year. And they couldn't even get that.

So I can't see this as being feasible anywhere.

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[712]

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Q. Are there medical situations where you think a surgical abortion would be preferable for a patient to an induction?

A. Yes.

Q. Can you give some examples of those?

A. If a woman has had prior surgery on her uterus, then depending on what kind of surgery and where the surgery was, it would be definitely preferable not to have her labor, if at all possible.

Can I go up to the diagram?

THE COURT: Yes.

THE WITNESS: In the—when the uterus is contracting, whether it be at term or if we give medicines to make the uterus contract to cause labor, the strongest part of the uterus is the part up at the top. And the part that is lower doesn't contract as strongly. And it makes sense. The uterus wants to contract from the top down to expel the fetus, as part of going through labor or induction abortion.

[713]

And so this muscle up here (indicating) contracts much more strongly. If an incision has been made in the upper part of the uterus, like with a myomectomy with fibroids have been removed in the past, or if a woman had a cesarean section with a scar included the upper part of the uterus, we recommend—in fact, we almost insist with women that if they are looking at having a delivery that they cannot have a vaginal delivery.

And we will go to large extents in general obstetrics practice to prevent them from going into labor by checking fetal lung maturity early, beginning around 36 weeks so that they don't ever go into labor.

If the fetus lungs are mature, then we do their c-section so they never have to have labor if they have had an incision up here (indicating).

And the same thing applies for labor induction abortion. Where a woman has had surgery in this part of the uterus, I would not want to give her medicines that would make her contract so strongly that it puts her at those same risks.

If a women insists that she is willing to take that risk, then we would still discuss it further. I have never met a patient who has said:

> "I insist on taking that risk as opposed to having a D&E."

But those would situations—that would be one [714] situation where there is a true, strong relative contraindication to labor induction, and a D&E procedure would be the—medically, the wiser choice, and even common sensically, the wiser choice.

BY MS. KRASNOFF:

Q. Does a woman every have any underlying medical conditions that would make induction riskier?

A. There are a lot of women who have significant medical problems, and that's one of the reasons that they are having a procedure at this point.

And it is not just that they were—the medical problems were just discovered, because there are a lot of women who have medical problems and have worked really hard to plan a pregnancy and try and get a pregnancy to a point where they could continue it.

But as the pregnancy progresses, just things are worsening in their medical situation, and they realize it is just not in their best medical interest in consultation with their doctor.

So very often, these are very desired pregnancies. In and those situations, if there's severe heart disease or respiratory disease, there are a lot of things about labor induction which, from fluid shifting, from the medicines that you need to give in the very prolonged time course of an average labor induction that a very short, controlled procedure [715] would be safer for the woman, keeping—I said this yesterday. An operating room is like an intensive care unit in that sense.

I would much rather have a procedure performed, medically, in my opinion, perform a procedure under very controlled circumstance, given all of her medical issues, than to have a prolonged process where I can't even guarantee when and if it will be successful.

Q. And what are the complications that go with induction abortion?

A. Bleeding, bleeding significantly enough to require transfusion. The bleeding can occur from abruption, as we talked about yesterday, infection, cervical injury, uterine injury. We are making the uterus contract at a time when it doesn't want to contract.

So we have to give very high doses of medicines, much higher than you would give at term, just because we are trying to override the fact that the uterus doesn't want to do this process. So you have to make the uterus contract so strongly that it can just break apart, to put it in simplistic terms.

And failure of the induction method, inability to successfully complete an induction. And then, retained tissue requiring a surgical intervention, anyway, anywhere from 20 to 70 percent, depending on the study and the methodology used.

Q. When you say "retained tissue," can that be a retained [716] placenta?

A. Primarily it is a retained placenta.

Q. And what percentage again?

A. It can vary from 20 to 70 percent, depending on the methodology. You can look at studies that say:

"In our situation, this is what we found."

But especially with the more modern techniques, the studies are incredibly small. So you have to, just like I mentioned with the studies earlier with incompetence that they are small, but it is the best we have, and we have to look at them for what they are worth.

Same thing with the modern abortion or modern labor induction abortion techniques. The study sizes are incredibly small. So when you look at the per-

centages of women who had retained placenta and needed intervention, you have to look at that within the realm of: they are small studies, so it can have a wider range.

Q. When you say "need intervention," what does that mean?

A. Usually a procedure like the D&E, just to remove the placenta, because the placenta rarely can fit through a suction cannula. At that point, you really have to—if it is at 20 weeks, you would have to grasp with a grasping instrument the same way to remove the placenta. So it is too large to fit through a suction cannula.

Q. What is DIC?

[717]

A. DIC is disseminated intravascular coagulopathy, which means it's words. It's not just letters. But it's a situation where most commonly because of prolonged bleeding or heavy bleeding that is going on for a long period of time, that the body is not only losing blood cells, but it's also losing the clotting factors that are in the blood. And the liver can only make these clotting factors so quickly.

So when there is a lot of bleeding over a shorter, prolonged period of time, the body no longer is able to clot. And there is a normal balance that we all have between clotting and not clotting. It goes on all the time in our body. And DIC is the situation where you've lost the balance. You've lost the race.

Q. Do you have an opinion on whether a surgical abortion after, say, 16 weeks versus a labor induction carries a greater risk of DIC?

A. I think over all both of them have an incredibly low risk. If I had to say which one would be greater, in my opinion it would be that the labor induction would have the greater risk just because it is a more prolonged procedure, bleeding over a longer period of time.

DIC is, again, just incredibly rare in a very short, controlled surgical procedure.

Q. In your opinion, Dr. Creinin, have there been improvements in the medications used to induce induction abortions in the [718] past 20 years?

A. Not significant improvements at all.

Q. Have the complications that we went over, have those changed in the past 20 years?

A. Not significantly, based on the studies that are available.

Q. And is your testimony about induction based in part on the research you did in order to prepare your book chapter?

A. Primarily, along with discussions with my co-author. One of the reasons that I decided to co-author the update rather than just do it myself was that Dr. Goldberg, who is my co-author, has a lot more extensive experience with misoprostol, the methods that many individuals choose to use for induction.

And so we decided to do this together. And we both came to the conclusion that the data that's available compared to the data from decades ago, 10, 15 years ago, methods that were used before that, that there really isn't much proven difference.

Nothing that is better. It doesn't mean that it is bad method, but there is just nothing that is better.

Q. Based on that medical literature, specifically, what is your conclusion about the relative safety of surgical abortions as they are performed today and inductions as they are performed today?

A. Based on the literature, I think they're equally safe. I [719] have—I think there is a lot of trends towards more safety with D&E. But, again, that data has to be taken within the realm of how conclusive one can be by looking at the data.

I think there's some recent publications looking at mortality from the CDC, that show that there's no difference in mortality, but a significant trend towards less with D&E.

But the statistics, the sample size doesn't allow you to say there is a big difference. And I think all of the literature is pretty similar in that realm, that one is not better, necessarily, than the other. But there are significant trends towards D&E being better.

And I think that a lot of it comes down to individual circumstances. And there are definitely medical circumstances and personal circumstances where one procedure, like a D&E, would be obviously preferable. And I would want—I think to best serve my patients, I would need to provide her with the options that would be best in that individual's circumstance.

Q. Are there any particular studies that you have relied on comparing the modern methods of surgical versus induction abortions?

A. There is not a lot of studies at this gestational age range. But the only one that's—

Q. What gestational age range?

A. I'm sorry. Beyond 18 weeks, 18 to 24 weeks.

[720]

There is one study by Autry, et al, that is a comparative study, and it's probably the best thing we have to look at the issue.

MS. KRASNOFF: That is Learned Treatise Five. If I may I approach, Your Honor?

THE COURT: Yes.

BY MS. KRASNOFF:

Q. Dr. Creinin, I have handed you learned treatise five, which is an article by Dr. Autry, and others, which is entitled:

> "Comparison of Medical Induction and Dilation and Evacuation for Second-Trimester Abortion," published in volume 187 of the American Journal of Obstetrics and Gynecology, in 2002.
>
> Are you familiar with that study?

A. Yes, I am.

Q. And what methods of abortion was it comparing?

A. This study compared labor induction methods versus dilation and evacuation for abortion between 14 and 24 weeks of pregnancy. And the most commonly used medical abortion regime was a misoprostol regime. Not all of the women had that method used. But I believe it was the vast majority, 75 percent, roughly. I would have to look for clarification, but I believe it was 75 percent had misoprostol inductions.

Q. And that is the same medications that are commonly used today?

[721]

A. Yes.

Q. What conclusions do you draw from the Autry Study?

A. When they—when the authors compared D&E versus labor induction abortion with the modern techniques that are used—misoprostol, primarily, and still some others—that the overall complication rate was much lower with D&E versus labor induction.

And those were just overall complications. When you look at severe complications they didn't really talk about those as significantly.

They did—there was a lot of analysis looking at women who had blood loss of more than 500 cc's, spending more time in the hospital, those sorts of things.

But this study tells me D&E appears safer. But to talk about it with conclusiveness, you would—you have to take this within the realm it is a retrospective study. There were a lot of things that were not controlled for. So it goes along with the idea that I can say:

> "The best data I have available tells me D&E is better."

Q. And are you—

A. But I still have to take it with a grain of salt, saying:

> "But I can't say with 100 percent certainty that it is always better for every person."

Q. Are you aware of any data that demonstrates that after 18 [722] or 20 weeks induction is a better method?

A. Not at all.

Q. In your opinion, how would you decide for any particular patient whether she should have a surgical abortion or an induction?

A. Well, I don't. I am not the one who ultimately makes that decision; the patient is.

Q. Dr. Creinin, do your patients ever ask you if the fetus is able to feel pain?

A. Yes, they do.

Q. And what do you tell them?

A. It's actually relatively a common question. I tell them that the best data that we have available, if you look at all the data, says that fetuses are unable to feel pain in the way that we, as humans, feel pain, until 26 weeks.

Q. What is that data that you are referring to?

A. It's a compilation review by the Royal College of Obstetricians and Gynecologists from 1997.

MS. KRASNOFF: This is Learned Treatise Nine, Your Honor, if I may give it to the witness?

THE COURT: Yes.

MS. CLARK: Your Honor, I just want to raise an objection. I am anticipating that she is going to ask for an opinion about fetal pain, and he wasn't been qualified to opine on fetal pain.

[723]

THE COURT: Is that—

MS. CLARK: I think he can talk about what he says to his patients, but—

MS. KRASNOFF: He is only going to report what he tells to his patients. He is not, in fact, an expert on fetal pain.

THE COURT: Go ahead.

BY MS. KRASNOFF:

Q. Dr. Creinin, this is Learned Treatise Nine, which was published by the Royal College of Obstetricians and Gynecologists, and is called:

"Fetal Awareness: Report of a Working Party," from 1997. Is this the data you are referring to?

A. Yes.

Q. And what is the Royal College of Obstetricians and Gynecologists?

A. That's the group or college of obstetricians and gynecologists in the UK, that is the equivalent of we know as the American College of OB/GYN, or ACOG. American College of OB/GYN or ACOG.

Q. And do you know why this report was prepared?

A. There were actually some questions raised by health care providers, as well as by Parliament, which is like our Congress. I guess I didn't need to say that here.

But just questions raised. There wasn't any dogma [724] that said to the Royal College:

"You need to look at this."

But there were enough questions being raised, both privately amongst the health care providers, and publicly, that the Royal College felt that a learned group of individuals needed to be brought together and

form a working party to review the evidence in an unbiased fashion.

Q. And who was in that working party, what kind of specialists?

A. There were fetal and neonatal medicine specialists, anesthesiologists, biologists, neurologists and a theologian and a lawyer.

Q. What did the Royal College Working Group conclude about fetal pain and the ability of a fetus to feel pain?

A. Can I read from what they said?

Q. Sure.

A. There are two main points.

MS. CLARK: I object. This is beyond what he tells his patients.

THE WITNESS: No, this is—I am sorry.

THE COURT: Yes. And you are not a lawyer, either.

THE WITNESS: No, I am. That's why I apologized.

THE COURT: Okay. Your response? She had objected before about the use of the treatise insofar as he was going to express an opinion on fetal pain. You indicated he was only [725] going to testify as to what he tells his patients. Now he is reading from a treatise. Where are you going?

MS. KRASNOFF: I would just would like to know based on this document if this is what he relies on and what he tells his patients based on this.

THE COURT: Do you have an objection to that?

MS. CLARK: For that simple question, no.

MS. KRASNOFF: Okay.

THE COURT: All right.

THE WITNESS: This is what I tell—roughly what I tell my patients. I can just tell you what I tell my patients.

BY MS. KRASNOFF:

Q. Yes, sure. Just tell me as if I were a patient.

A. That there are multiple things that are necessary—the simple thing I tell my patients, and then I will tell you when they want to know further detail exactly what the working party found.

But the simple way I tell it to them is that pain is something that we understand as conscious beings, and that pain requires us to not only sense something, but to process it as painful.

And a good way of understanding it is if you or someone you know has had major surgery and has been put under general anesthesia, that you don't feel pain during the surgery. It is only once you wake up from the surgery that you [726] feel the pain.

So there has to be a consciousness in order to feel pain. And what the working party found is what I base that on is that you can look at the development of nerve fibers in the periphery, and you can look at the development of nerves that go up to the brain, but then—

MS. CLARK: I will object. I am not sure if this is what he actually tells his patient or if he's explaining how he forms the decision to tell his patients. I think he can testify as to what he tells his patients, but not why

he tells his patients that. That seems to be expert testimony.'

THE COURT: I disagree with that, Counsel. I think that I am going to allow him to explain to me why he tells his patients what he tells them.

THE WITNESS: So, that the nerves need to also develop that go up to the brain. And then, within the brain itself, there has to be the connections that form for the brain to process this as something painful. And a lot of—and I do have patients that ask me, because they have looked on the internet and heard about studies that have shown that fetuses feel pain.

And what a lot of those—virtually all the studies look at are things called autonomic reflexes or automatic reflexes.

And, again, the way I explain that to patients would [727] be if you were in a coma, and I tapped your knee, most people know that the knee reflexes. You hit the knee and the leg pops up.

If you were in a coma, you would still have that reflex, because the nerves go from your knee to your spinal cord, and then right back. It is an automatic reflex. It doesn't require processing in your brain to say:

> "I felt pain in my knee, therefore I am going to kick." It is an automatic reflex.

So that in no way says that you felt pain. It is an automatic response. And that is what most of the studies on fetal pain show.

So when patients ask me about what they read, that is what I tell them.

BY MS. KRASNOFF:

Q. And based on what you read, and for your practice only, do you feel you need to do anything different for abortions prior to 24 weeks, based on the issue of fetal pain?

A. I don't feel I need to. And also, when I read in the literature, the working party summarizes—concludes you don't need to, based on all of these things, also.

Q. Dr. Creinin, do you ever utilize a chemical agent to cause fetal demise prior to performing an abortion?

A. No.

Q. And why not?

[728]

A. Because I don't feel there is any benefit to my patients to doing so before the procedure. And it adds an extra step. And if there is no benefit, and I have to do something, then I just get risk without benefit.

Q. What are the risks that could arise from that injection?

A. In putting a needle into somebody's belly, first there is the physical pain issue of it. There is the—for some women—the trauma of seeing that I am doing something, because a lot of women ask:

> "Am I going to see anything during the abortion? I don't want to see anything."

So even putting the needle in would be part of what they would see.

The needle can go through blood—large blood vessels that feed the uterus, and specifically the placenta.

So you could have significant bleeding. You could cause infection because you are putting a needle in. And albeit, many of these risks are small, if there is no benefit then all I get is risk.

MS. CLARK: Your Honor, I will object on a lack of foundation. He said he doesn't do any injections that cause fetal demise. I don't understand what his basis is. He doesn't have a basis for those opinions.

THE COURT: I think that he said that he doesn't do it because of the risk. It seems to me the basis would be his [729] prior analysis of those risks in order to give advice to his clients.

MS. CLARK: I mean, it may be—I don't think—I don't think a foundation has been laid.

THE COURT: Why don't you lay an appropriate foundation?

MS. KRASNOFF: We are actually done with this topic, but that is precisely was he was testifying to. Is that—

BY MS. KRASNOFF:

Q. Dr. Creinin, is that the reason why?

A. Those are the reasons why I don't do that procedure.

Q. And are you familiar based on your practice treating patients who are pregnant with doing a similar type procedure?

A. Yes, with amniocentesis.

Q. Do you ever perform abortions for women who need an abortion for a life-threatening condition?

A. Yes.

MS. KRASNOFF: May I put up a blowup?

BY MS. KRASNOFF:

Q. If I could as you to read the second sentence which starts with this subsection to yourself.

"Based on that, the Partial-Birth Abortion Ban Act, would allow you to perform a banned abortion when it is necessary to save the life of a mother whose life is endangered by a physical disorder, [730] physical illness or physical injury."

Would you feel comfortable performing the life saving abortions you perform now under this exception?

A. Not totally comfortable. I would have to hope that other people agreed with me or with the patient's primary health care providers, that they agreed. If it leaves it open to speculation by other people, there is no definition of "life endangerment," like: how much does it need to be? Does it need to be that there is a 50 percent chance she'll die? Does it need to be a 20 percent she'll die. I don't—it is not clear to me.

Q. And Dr. Creinin, one of the findings of the Partial-Birth Abortion Ban Act is that that act will advance the interest of the medical profession. Do you believe that this Act that is at issue in this case advances the interest of the medical profession?

A. Not at all.

Q. Why not?

A. Part of being a medical professional is to provide care as best as possible for in that individual person, and every circumstance is different. And I can't ever lay a general rule that everything will always be the same for everybody. There is things I see every month or two that I have never seen before in the last 10 to 11 years. So there is no way I could lay a general rule.

[731]

So preventing me from providing service—and the law, as it is written, is not about a specific procedure. It is about techniques that are used during surgical—during surgical procedures, so that this would prevent me from providing methods of abortion that are well-proven to be safe for women.

So I don't think this advances medicine. I think it hinders—severely hinders the practice of medicine.

* * * * *

[740] pieces?

[CROSS-EXAMINATION BY MS. CLARK]

A. Correct.

Q. You don't tell your patients that the fetus will come out intact?

A. No.

Q. And in a D&E procedure the fetus is removed in pieces to be as safe as possible for her?

A. I tell her that's the reason we are doing the procedure that way.

Q. You wouldn't tell your patient anything that is incorrect, would you?

A. To the best of my knowledge, I would not.

Q. And you remove the fetus in pieces because you want to minimize the amount that the cervix is open, correct?

A. Correct.

Q. And you minimize the amount of dilation in a D&E procedure in order to perform an abortion that is as safe as possible?

A. Correct.

Q. And when you are doing a D&E that involves dismemberment of the fetal parts, you perform a gentle twisting motion when you meet resistance, correct?

A. Correct.

Q. And the purpose of the twisting is to avoid tearing the cervix, right?

A. Not entirely.

* * * * *

[744] woman?

A. I don't understand what you mean by "significant."

Q. If you increase the number of dilators than what you use, that increase in dilators would increase the level of pain that the woman would experience; is that correct?

A. It could, but not always.

Q. Is it increase in the level of pain one of the reasons why you don't increase the number of dilators?

A. For my patients in my situation, yes.

Q. And more dilators also could cause injury to the woman's cervix; isn't that correct?

A. More of anything can cause injury to anything. That is a given.

Q. So many your answer would be "yes" to that question?

A. It's not—yes, that's because it is an obvious question.

Q. You don't set out to dilate the cervix more in order to increase the likelihood that you will be able to remove the fetus intact; is that correct?

A. In order to remove the fetus completely intact, that's correct.

Q. And it is your opinion that in your hands it is safer for you to perform a D&E abortion involving dismemberment of the fetus than it is to perform an intact D&E?

A. Correct.

Q. Now, you have encountered situations in which you are * * *.

* * * * *

[748]

Q. Because if the fetus were close to 24 weeks, and you were performing a transvaginal surgical abortion you would be concerned about delivering the fetus entirely intact because that might result in a live baby that may survive, correct?

A. You said I was performing an abortion, so since the objective of the abortion is to not have a live fetus, then that would be correct.

Q. In your opinion, if you were performing a surgical abortion at 23 or 24 weeks and the cervix was so

dilated that the head could pass without compression, you would do whatever you needed to do in order to make sure that the live baby was not delivered, wouldn't you?

A. Whatever I needed, meaning whatever surgical procedures I needed to do as part of the procedure? Yes. Then, the answer would be: yes.

Q. And one step you would take to avoid delivery of a live baby would to be to deliver or hold the fetus' head on the internal side of the cervical os in order to collapse the skull; is that right?

A. Yes, because the objective of my procedure is to perform an abortion.

Q. And that would ensure that you did not deliver a live baby?

A. Correct.

Q. You would agree that a D&E in the second-trimester pregnancy is an extremely safe procedure, right?

[749]

A. Yes.

Q. And you would agree that the forceps used in a D&E do not pose a risk of damaging the cervix?

A. No, I don't agree with that.

MS. CLARK: Your Honor, may I approach?

BY MS. CLARK:

Q. Dr. Creinin, I took your deposition about a month ago; isn't that correct?

A. Month-and-a-half, yes.

Q. And you told the truth in that deposition, right?

A. Yes.

Q. And you had the opportunity to review your deposition transcript, right?

A. Yes.

Q. And you signed that deposition transcript after making a few changes; isn't that right?

A. Yes.

Q. I would like to direct your attention to page 147, line 22.

MS. KRASNOFF: I am sorry. What line again?

MS. CLARK: Line 22.

BY MS. CLARK:

Q. If you would read to yourself through page 148, line 4.

A. Yes.

Q. Would you now agree the forceps used in a D&E does not pose a risk of damaging the cervix?

* * * * *

[751]

A. From most. For virtually all women, yes.

Q. Doctor, for the surgical abortions that you perform 18 weeks and one day, and later, most of your patients do not return to you for follow-up care, correct?

A. Correct.

Q. So, if you performed an abortion, and if the woman had a subsequent pregnancy, say, two years

later, and experienced a pre-term birth during her subsequent pregnancy, you are unlikely to know about that?

A. Correct.

Q. Doctor, in your direct testimony you testified about whether cervical incompetence is a complication that a woman make suffer as a result of having a surgical abortion; is that right?

A. I am sorry. Can you repeat the question?

Q. I am trying to go slow.

In your direct testimony, you testified about whether cervical incompetence is a complication that a woman may suffer as a result of having a surgical abortion, right?

A. Correct.

Q. And is it correct that cervical incompetence does not manifest itself until a subsequent pregnancy?

A. Correct.

Q. Doctor, one of the articles you relied upon in forming your opinion about the possibility of a risk of cervical * * *.

* * * * *

[784]

* * * * *

[REDIRECT BY MS. KRASNOFF]

Q. You were discussing multiple passes versus intact. Is one category of procedure where you remove the fetus completely intact without having to take or to compress the head?

A. Correct.

Q. A different category which you were calling intact D&E, is where you removed the fetus up to the calvarium, and you use a scissors and suction to remove the fetus; is that correct?

[785]

A. Scissors to puncture the skull to drain, right. Correct.

Q. The third category which I think you called a D&E, you may remove the fetus up to the point of the aftercoming head, but then disarticulate further. That would be a D&E?

A. Correct, and any of the—

THE COURT: I didn't under the distinction between the second and third.

MS. KRASNOFF: He's—

THE COURT: Second and third category.

MS. KRASNOFF: Oh, the second was specifically using a scissors to pierce the base of the skull and the suction instrument to remove the intracranial contents.

THE COURT: Okay. The third was—

MS. KRASNOFF: The cranium lodges and uses disarticulation to remove the fetal trunk, and then remove the skull, thereafter.

THE COURT: All right. And, Doctor, the category in which you described three prior experiences, was that in the first category or the second category?

THE WITNESS: Second.

THE COURT: The second category?

THE WITNESS: The second was intact. That is what is medically called an intact D&E procedure.

THE COURT: Okay. And you have not had any experience with the first category?

[786]

THE WITNESS: No.

BY MS. KRASNOFF:

Q. You took out one, two and three.

A. The first category being that the fetus comes out completely intact?

THE COURT: Right.

THE WITNESS: There have been situations, most commonly if there is a multiple pregnancy and the first one is removed by D&E, and then the second one because the cervix is very pliable at that point will come out completely intact.

THE COURT: Have you had that experience?

THE WITNESS: Yes. In all of those situations, though, regardless of whether the fetus comes out completely intact, intact up to the head, and I do a procedure on the base of the skull, or I dis—or it comes out completely at the level of the head, and I disarticulate it, all of those have at times gone intact or relatively intact to the level of the umbilicus or greater and would violate the law.

THE COURT: Okay.

BY MS. KRASNOFF:

Q. And do you know at the outset whether it is going to be one of those three?

A. No.

Q. I think you testified about this on direct a little bit.

Why do you in the abortions you do not seek to get more [787] dilation?

A. Because I'm trying to balance the patient's desires and needs and comfort so that I can put in—so I am trying to make it so when she goes home, she is as comfortable as possible, with balancing with me getting enough dilation to do the procedure. And that my goal is to get enough dilation to safely do the procedure, realizing sometimes it may be more.

But my primary objective is for her to go home with a low likelihood of delivering at home, because she doesn't want that. We talked about that ahead of time, and with her being comfortable.

Q. Miss Clark used the word "minimizing the dilation."

Do you consider what you are doing to be minimizing the amount of dilation?

A. I think minimizing requires comparison. I think it is more that I am trying to achieve an amount that I consider to be a minimal amount to successfully do the procedure, but I am not trying to minimize the amount.

Q. I believe you testified that—about taking acts to prevent delivery of a live fetus. Would you ever do that if in your medical judgment the fetus was viable?

A. No, I wouldn't be doing this procedure on a viable fetus.

Q. You don't perform any abortions on viable fetuses, do you?

A. No, I don't. By law in Pennsylvania I cannot.

* * * * *

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C 03-4872 PJH

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. AND PLANNED PARENTHOOD GOLDEN GATE, PLAINTIFFS

v.

JOHN ASHCROFT, ATTORNEY GENERAL OF THE UNITED STATES, DEFENDANT

TRANSCRIPT OF PROCEEDINGS
Tuesday, Apr. 6, 2004
Volume 5

BEFORE THE HONORABLE
PHYLLIS J. HAMILTON, JUDGE

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[CAROLYN WESTHOFF, M.D.—DIRECT EXAMINATION]

[791]

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Q. Good morning, Dr. Westhoff.

A. Good morning.

Q. Are you a board certified OB/GYN?

A. Yes, I am.

Q. And where are you currently employed?

A. I am a professor at Columbia University at New York City.

Q. And what are you a professor of?

A. I am a professor of obstetrics and gynecology in the college of physicians and surgeons. And I'm also professor of epidemiology and of population and family health in the Mailman School of Public Health.

Q And are you an epidemiologist in addition to being an OB/GYN?

A. Yes, I am.

Q. And are you affiliated with any hospital?

A. I am attending physician at the New York Presbyterian Hospital.

[792]

Q. And in addition to being an attending physician at New York Presbyterian Hospital, do you have other positions?

A. I am the medical director of our family planning clinics, and I'm also the director of the special GYN services.

Q. And is that the special GYN services at a particular institutions?

A. The special GYN services is at Allen Pavilion, which is a building that is part of New York Presbyterian Hospital.

Q. And did New York Presbyterian Hospital used to be called Columbia Presbyterian Hospital?

A. Yes, about six or eight years ago we merged with New York Hospital, so there are multiple

campuses now that are all part of New York Presbyterian.

Q. And do you have a private medical practice?

A. I am part of the faculty practice in the department of OB/GYN.

Q. And what services do you offer in that private practice?

A. My private practice is a half day a week, and that is focused on providing care for abortions, miscarriages and contraceptive consultation.

Q. And what services are provided by the special GYN services program?

A. Special GYN services provides care for miscarriage and abortion up until 24 weeks, and tubal ligations.

Q. And approximately how many patients do you see annually at [793] the special GYN services?

A. There are a total of between two to 3,000 visits. There are about—they are divided among the various services we offer.

Q. In your private practice approximately how many patients do you see a year?

A. See about 500 patients.

Q. And at the special GYN services, are there other physicians besides yourself that are providing services?

A. Yes. There are about five physicians who are part of my core group, part of my academic division. And then, there are another six or eight doctors who are part of the department of OB/GYN who may work with us one day a week or one half day a week.

Q. And do you supervise all of those physicians?

A. Yes, I do.

Q. Do you yourself perform abortions?

A. Yes, I do.

Q. For how long have you been performing abortions?

A. I started performing abortions during my residency training starting in 1978.

Q. And what type of abortion procedures are offered at the special GYN services?

A. We provide surgical abortion in the first and second-trimester. We also provide medical abortion using [794] mifepristone or methotrexate in the first-trimester.

Q. Do you perform induction abortions at special GYN services?

A. The special GYN services is completely outpatient service, and we don't provide inductions on that unit.

Q. Have you ever provided inductions in your career?

A. Yes, I have.

Q. And why don't you currently provide inductions?

A. There is currently not need for me to offer induction services. In our department of OB/GYN there are many other physicians, particularly those in maternal fetal medicine, who know how to provide an induction abortion. And they occasionally do so for their patients. But they refer all patients requesting D&E to our service.

Q. And in your practice, what are--I think—did you testify to what gestational age you provide D&E's at special GYN services?

A. We provide D&E's through 28 weeks, which is the legal limit in New York state.

Q. Through twenty-eight weeks?

A. Did I misspeak? I'm sorry.

Q. Yes, doctor.

A. Through 23 weeks.

Q. Through 23 weeks. Is that 23 and six-seventh—

A. Yes.

Q. —weeks. Okay.

[795]

And what are some of the circumstances in your practice that women are having second-trimester abortions, just generally?

A. Well, we certainly see some women who have personal and social catastrophes. And we see many women who have genetic abnormalities or anatomical abnormalities of the fetus that are diagnosed in the second-trimester.

And we also see women who have medical illnesses that make continuing on to parenthood at this time more dangerous for them who decide to abort.

Q. Do you know approximately what percentage of your patients are terminating the pregnancy due to a serious fetal abnormality?

A. It is approaching half of the patients.

Q. And does Columbia University offer any training in abortion procedures?

A. Yes, we do.

Q. What type of abortion procedures are taught?

A. All of the types that I just described.

Q. And do you teach the intact variant of the D&E procedure at Columbia?

A. Yes, we do.

Q. Have you authored any publications?

A. Yes, I have.

Q. Just generally, what subject areas have you authored [796] publications in?

A. My main focus has been in the area of family planning, so contraceptive development effectiveness, contraceptive evaluation, early medical abortion. And I also am interested in ovarian tumor and have done a number of studies looking at ovarian cancer and benign ovarian cysts and tumors.

Q. And are the publications listed on your curriculum vitae?

A. Yes, they are.

Q. Do you sit on any governmental advisory committee panels at any level?

A. Yes, I do.

Q. Could you state some of them for us?

A. Yes. I just completed five years as a member of the U.S. Preventive Services Task Force.

I have served on NIH study section to evaluate grant applications. And I am also a member of or chair

of several data safety and monitoring boards for a number of NIH-sponsored clinical trials.

MS. GARTNER: Your Honor, may I approach the witness to hand her her CV?

THE COURT: Go ahead.

BY MS. GARTNER:

Q. Dr. Westhoff, I am going to hand you what is Exhibit 67.

MS. GARTNER: Your Honor, because we didn't know if Dr. Westhoff was going to be testifying in person, we [797] designated this exhibit in the way that it was. This is her curriculum vitae. And the way that it was used in her deposition testimony, and for some reason I don't fully understand, it is stapled together. It's a copy of Dr. Westhoff's expert report and her CV, and her declaration in the New York case.

So just so you understand, we are really only using it for the CV, but it was designated as three documents stapled together.

BY MS. GARTNER:

Q. Dr. Westhoff, if you turn to the third page of that document, is this your curriculum vitae?

A. Yes, it is.

Q. Is this document an accurate summary of your education and experience?

A. Yes, it is.

MS. GARTNER: Plaintiffs would move Exhibit 67 into evidence.

THE COURT: Any objection?

MS. CLARK: No objection. And, Your Honor, I would just suggest we can keep the labeling purposes and maybe take apart the report and the background, and just submit the CV.

MS. GARTNER: That's fine with us, Your Honor.

THE COURT: All right. We can deal with this later when we deal with all of the Exhibits.

[798]

We will admit it at this time.

THE CLERK: Sixty-seven into evidence.

(Plaintiffs' Exhibit 67

Was received in evidence.)

MS. GARTNER: And, Your Honor, we would move to qualify Dr. Westhoff as an expert in obstetrics and gynecology, abortion practice and epidemiology.

THE COURT: Any objection?

MS. CLARK: No objection.

THE COURT: All right. She'll be accepted as such.

BY MS. GARTNER:

Q. Dr. Westhoff, do you have an opinion regarding the safety of D&E's in which the fetus is extracted intact?

A. Yes, I do.

Q. And what is that opinion?

A. That it is an extremely safe way in which to accomplish second-trimester abortion.

Q. And what is the—in what way do you think intact extraction is a safe way to accomplish second-trimester abortion?

A. Okay. In contrast to dismemberment D&E? The benefits that I attribute to this approach, based on my experience using this approach with my patients, is that it minimizes the passage of instruments into and out of the uterus, and therefore minimizes the risk of perforation with those instruments.

[799]

It also minimizes the creation of sharp fetal fragments that may lead to laceration during extraction. And that, in addition, it may sometimes be quicker and, therefore, lead to less blood loss in my patients.

Q. And in what way does it—looking at the reduction in the risk of injuring the woman with the sharp, boney fragments, if you can explain in a little more detail how that happens?

A. Well, I need to explain that by contrasting it to a D&E that involves disarticulating the fetus. When the fetus is disarticulated, the skin and soft tissue covering the bones is disrupted, so sharp fragments of bone are exposed.

And in the process of exposing them, grasping them and removing them from the uterus there is the possibility that those boney fragments can lacerate at any level of the uterus and the cervix itself during extraction.

When the fetus is removed intact, the entire fetus remains covered with skin and soft tissue. There are no boney fragments. Therefore, there is minimal or

perhaps zero risk of creating such lacerations during the extraction.

Q. Can the boney parts perforate the uterus in addition to lacerating it?

A. Yes, they can.

Q. Have you ever observed uterine perforation or laceration or cervical laceration as a result of instrument passes in a D&E with disarticulation?

[800]

A. Yes.

Q. Have you ever observed that happening as a result of sharp fetal parts?

A. Yes, I have.

Q. Have you ever observed uterine perforation or cervical laceration in a D&E where the fetus was extracted intact?

A. Based on our experience on our own service over the previous five years or so we have not had any perforation or lacerations occur following—during or following an intact D&E.

But we have had those complications occur during and following dismemberment D&E.

Q. Is there an advantage to intact D&E in terms of not having retained tissue in the uterus after the procedure?

A. Yes, there is.

Q. What is the—what is that—can you explain that advantage in a little more detail?

A. Yes. When the fetus is removed in parts we attempt to account for all the parts on the operating

table at the completion of the case. But it is entirely possible that small fragments of soft tissue can remain inside the uterus that we can't be sure of.

And even with, for instance, the sonographic scan, we may not be able to detect those, and that can lead to subsequent infection or hemorrhage on the part of the patient.

[801]

We have, in fact, on our service had a case with a small fragment of retained skull leading to those very difficulties and requiring a second procedure subsequently to relieve those symptoms.

Q. Do you know whether that particular procedure was done with ultrasound guidance?

A. I don't recall with certainty.

Q. And you also indicated that a potential advantage of the intact extraction is the shorter period of time for the procedure; is that right?

A. Yes. That may be true.

Q. And why would a shorter procedure time be an advantage?

A. In general, patients may be bleeding throughout these procedures to some degree, and the shorter the procedure is, the less blood loss there may be.

For a patient who starts a procedure medically compromised due to some illness, patient who perhaps starts the procedure anemic from the very beginning, reducing blood loss reduces the difficulties that the patient may experience.

That is one reason why the potential for shorter operating time benefits the patient.

Q. And is there an advantage to the intact extraction in terms of how the fetal head is removed from the uterus?

A. The collapsing of the fetal skull by using an incision at the base of the skull is, in my opinion, based on my [802] experience, a safer approach, because the skull, the base of the skull is at the level of the cervical os, and I can visualize it directly when I make that incision.

So there is no blind use of instruments, and therefore, minimal or no risk from the use of the instruments.

In contrast, when I am retrieving a fetal skull that is floating free in the uterine cavity, I must pass instruments in an attempt to grasp it inside the uterus. And that is a blind use of instruments, which has more potential for perforation.

Q. And Dr. Westhoff, in your opinion, does the intact variant of D&E in any way facilitate the grieving process of women that are ending their pregnancy, that was a wanted pregnancy but they are ending it due to an anomaly or a maternal health condition?

A. Yes, it does. In a particular case in the last year, as an example, a patient who was aborting twins due to complications during the pregnancy absolutely did not want to go through labor and didn't want to go through an induction, but expressed the desire to hold these babies after the procedure.

We were able to deliver both of them intact and present them to the woman to hold with clergy and her family present. And she was very grateful for that opportunity.

And it is very similar to how on our obstetric unit we may allow a patient to hold a stillborn fetus.

[803]

Q. And we have had questions previously in this case about whether when you are doing that type of procedure where you are reducing the fetal head by puncturing it in the back, does that—does the fetal face remain intact in a way that the parent can hold it and not feel disturbed?

A. Yes. It may not be anatomically obvious here. The incision in the base of the skull leads to a collapse of the top and the back of the skull. The skull remains covered by scalp, and—but it collapses in the back.

The face is not disturbed at all, and it is just that the back of the head then appears collapsed, with a sort of wrinkled scalp covering it. And it is not as distorted as one might fear.

Q. And is it—other than that case that you described of the woman who was terminating the pregnancy with the twins, do other patients also seek to hold the fetus in your practice?

A. Yes, we do. Yes. That is the most recent patient who I remember, but we have several patients every year who express This desire, and we are able to accommodate that.

Q. Is it the case, Dr. Westhoff, that induction abortions also would typically result in an intact fetus?

A. Yes. An induction is successful would result in an intact fetus.

Q. So why then, given that a woman could obtain an intact fetus with induction method, why is the intact D&E—why does [804] that offer advantages to her?

A. In the United States as a whole, 90 to 95 percent of women choose D&E over induction. And the reasons my patients tell me that they do not wish to undergo an induction is they don't want to go through the experience of labor.

Q. Dr. Westhoff, have you offered expert testimony in other court cases before this federal law was passed relating to bans on so-called partial-birth abortion?

A. Yes, I have.

Q. And was the first time in 1997, in a case in Michigan?

A. Yes, it was.

Q. Since 1997, when you first testified in the case relating to the subject of so-called partial-birth abortion, has your medical practice with respect to the abortions that you performed and the gestational ages at which you perform them, has that changed?

A. Yes, it has. at the time I first testified in Michigan, we did not have a full-scale abortion service at what was then Columbia Presbyterian. And in the year since then, I began the service that now exists, so that we can offer abortion care to all the patients of all the doctors in our medical center, as well as patients in our local community.

And so, I have a great deal more experience with this technique now than I did in 1997 when I first testified in Michigan.

[805]

Q. Is the intact D&E technique a routine part of your abortion practice now?

A. Yes, it is a routine part of my personal practice, and the other attending physicians who are part of our group all strongly prefer to use the intact method whenever possible for patients in the second-trimester.

Q. And as a result of the development of your medical practice, has your thinking about D&E's, and, in particular, your thinking about intact D&E's, evolved?

A. Yes, it has.

Q. Can you explain that a little bit?

A. I think that in the late 1990's, I definitely saw potential advantages of intact D&E, but I now feel more certain that those advantages are, in fact, real advantages based on my personal experience using the technique.

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Q. Can you summarize for us what were the results of Dr. Chasen's study regarding the comparative complication rates of intact D&E with D&E that resulted in disarticulation?

A. Yes. Overall for the subjects in the study—and there were about 400 in total in the study—the overall complication rate was about 5 percent. And this was the same for the intact and the disarticulation varieties.

What got my attention in the two groups is that, first of all, the gestational age was greater for the women who underwent intact D&E. And we know in induced abortion that complication rates increase with gestational age.

So for the group with the advanced gestational age to have the same 5 percent complications as the group with the lesser gestational age, is, I think, a result that favors the intact D&E approach.

Q. Let me just interrupt you for one minute. Do you recall what the difference in the median gestational age was in the two groups?

A. Reported here in the article it was 21 weeks for the dismemberment group and 23 weeks for the intact group. So there's a two-week difference.

Q. At that gestational age is that two-week difference a [809] significant difference, in your opinion?

A. I think that is a substantial difference, and it's a clinically important difference.

Q. So would you—if you had two groups of patients, one at a median age of 21 weeks and another at median gestational age of 23 weeks, both having disarticulation-type D&E's, would you expect to see a difference in complication rates?

A. I would expect that if a woman had the same technique used to see more complications in the subgroup with the more advanced gestational age.

Q. So what conclusions, if any, can you draw from the fact that in Dr. Chasen's study the women having the abortions at 23 weeks by intact variant had the same percentage of complications as the women having

disarticulation D&E's at a two-week earlier gestational age?

A. The finding that the complication rate did not increase with advancing gestational age suggests a benefit for the women in the subgroup that had intact D&E.

Q. And how many complications, if you can recall, were recorded in total in Dr. Chasen's study?

I can withdraw. I don't want to waste your time looking for that number.

A. Yes. I think it was 19, but I would have to refer to the article to find the number for sure.

What impressed me about the complications is that [810] there were only a few serious complications, such as perforation, sepsis and amniotic fluid embolus. And all of the serious complications occurred in the disarticulation D&E group. None of the more serious complications occurred in the intact D&E group, which I think, again, implies a potential benefit to being a member of the intact D&E group.

And this distribution of complications is similar to what we have observed in our own practice at our campus of New York Presbyterian.

Q. Dr. Westhoff, if you recall, did Dr. Chasen also study in this—in this publication, did he study the impact on subsequent pregnancies of the two variants of D&E?

A. Yes, he did.

Q. And based on your review of the study, what did they conclude?

A. For all of the patients who went on to have another pregnancy that was cared for at the same medical center they followed up for the outcome of the subsequent pregnancy. And there was not a statistically-significant difference in premature delivery between the two groups.

And, in fact, the women who, in the intact D&E group subsequently had a premature delivery had, in fact, preexisting problems with premature delivery prior to the intact D&E.

So, that is—reduces concern about that issue.

Q. Reduces concern. Can you just explain that a little more?

[811]

A. Reduces concern that intact D&E may lead to more premature deliveries in the future.

Q. And based on your review of the study, do you agree with Dr. Chasen's conclusions?

A. I think that as I interpret the data, I find his conclusions to be very conservative.

And my interpretation of his data is that it tends to favor intact D&E. And his conclusions are only that the two approaches are similar in safety.

Q. As an epidemiologist, in your opinion was the number of the subsequent pregnancies that were followed in the study a sufficient number on which to base a conclusion?

A. The number of pregnancies that were followed would be enough to detect large differences between the two groups. If there are modest differences between the two groups, one would need to observe a

larger number of pregnancies to detect very modest differences.

Q. Dr. Westhoff, I would like you to describe for me briefly how you in your service do D&E abortion beginning at approximately 18 or 19 weeks gestation.

A. We first do an assessment of the patient one and often two days prior to the scheduled surgery. We assess her gestational age and the reasons she is being referred. And, in fact, assess her desires for D&E versus induction.

And as Dr. Creinin testified, not every woman [812] arrives to our service with an adequate amount of information about the alternatives. And if the patient then wants to go forward with a D&E, we at that point will complete the process of informed consent both regarding the use of osmotic dilators, such as laminaria, as well as the surgical procedure itself.

On completion of the assessment in those steps, we will do our first insertion of laminaria using local anesthetic at the time of laminaria insertion.

For patients who are past 20 weeks and for patients who have never given birth before after 18 or 19 weeks, we generally will use two days of laminaria insertion.

For patients who have given birth previously we may only do one day of laminaria insertion.

We make that assessment based on both the gestational age and the condition of the woman's cervix when we examine her for the first time. If she is going to have two days of laminaria, she'll return on the second day for a brief visit during which we remove the

first set of laminaria and, again, using local anesthesia, insert a second set of laminaria.

The patient then returns on the operative day with an empty stomach as assessed by our anesthesia doctors.

And at these gestational ages, our anesthesiologists—and we concur—prefer to use general anesthesia for these cases.

[813]

After induction of general anesthesia, we remove the laminaria, assess the state of the cervix, and then in the safest approach possible, we will remove all of the fetus, the membranes and the placenta.

Q. When you do the D&E, after you've removed the laminaria, do you use any instrument to bring the cervix closer to the vaginal introitus?

A. We use an instrument called a tenaculum which grabs the cervix. And the reason we do this is because the uterus is not attached inside a woman's body by any bones. The uterus is only attached with ligaments.

And, therefore, it is—can possibly flop around a little bit inside the woman's pelvis. In order to stabilize the uterus and hold it steady and straighten the cervical canal, we use a tenaculum to pull down on the uterus so that it remains as stationary as possible during the procedure.

And it is only then that we would begin to—begin the procedure inside the uterus.

Q. And how close does the cervix come to the vaginal opening after you pull it?

A. Okay. Every woman is different. It may be at or slightly above or below the vaginal opening. And this is different for each patient.

Q. Okay.

And how far does the cervix dilate during the D&E?

[814]

A. Our cervical preparation is the same for all of our patients, but each patient individually can respond quite differently to the laminaria. So if some patients will on the operative day have 1 or 2 centimeters dilation. Other patients will have three or four, five centimeters dilation, which, in our experience, is just largely determined by how the woman's body responds to the laminaria.

Q. And is getting too much dilation a concern?

A. I have never been in a situation where I felt the woman had too much dilation.

Q. Talking now about the evacuation part of the procedure, approximately how many instrumental passes does it typically take to evacuate the uterus completely?

A. There is a wide range. I can, of course, in some cases either with my fingers or with an instrument bring down the fetus on my first attempt. And as I continue the extraction, I may need to do no additional insertions of fingers or instruments inside the uterus, but am able to complete the entire abortion in a single pass.

In contrast at the other extreme, we can insert grasping forceps into the uterus and have multiple

passes where even on the first few passes we do not grasp any part of the fetus successfully, but need to make multiple passes, 10 or 20 passes in order to complete the delivery of the fetus in parts.

Q. You said that you would use either forceps or your fingers; [815] is that correct?

A. That's right.

Q. How would you decide which approach you are going to use?

A. Well, I first examine the cervical opening that both the length and the dilation of the cervix with my fingers, and it may be that I can immediately palpate fetal parts within reach of my fingers. And in which case I will use my fingers rather than an instrument.

If I cannot reach any fetal parts with my fingers, then I will use an instrument instead.

Q. And once you start the procedure with instruments, do you complete it with instruments? Or might you bring out a presenting part with an instrument, and then switch to your fingers?

A. Yes. Each procedure proceeds very individually, and so each step of the procedure will depend really on just what happened in the one step before it. And for each step of the procedure I want to do what is going to be safest at that moment.

So, yes, in fact, I have had cases where I may bring down and extract a leg with an instrument and disarticulate that leg, but because the position of the fetus comes down in the uterus during that maneuver, I may then be able to bring down the next leg with my fingers. And, in fact, the rest of the fetus will follow.

[816]

So, similarly, I could start with my fingers and then in addition need to use instruments. So the combination of maneuvers I use are determined one at a time on an individual basis to minimize the total number of passes and maximize patient safety at each step of the way.

Q. And why do you want to minimize the number of passes?

A. Each pass of instruments into the uterus, in my opinion, carries with it at least the potential risk of perforating or lacerating the uterus. So the fewer passes, the smaller that risk will be.

Q. And in your practice do you ever remove the fetus intact to the point where the calvarium lodges at the cervical os?

A. Yes, I do.

Q. And do you attempt to do the D&E in such a way that that occurs?

A. Yes, I do.

Q. And at what point in the procedure do you know if you will be successful in doing the D&E in that way?

A. In a sense we don't actually know until it is over, because each case proceeds on an individual basis. So I will only know that I have completed an intact D&E at the very end when I have completed it.

I really do not know each step of the way exactly what the next step is going to be or the results of the next step until it has been accomplished.

[817]

Q. So in that circumstance where the calvarium lodges at the os, how do you complete the procedure in an intact D&E?

A. With continued traction on the cervix that we described earlier, I can with direct visualization incise the base of the skull with scissors.

At that point in some cases the contents of the skull will drain spontaneously. In other cases we will insert a suction tube to drain the skull contents. Because the bones of the skull are very soft at this stage of gestation, as soon as the skull is empty, it will collapse. And when the diameters are therefore reduced, the entire skull will fit through the cervical opening without any further manipulation.

And that will complete the procedure.

Q. And do you also tend to have to reduce the diameters of the calvarium when you are doing a disarticulation-type D&E?

A. Yes. The skull is the largest diameter of the fetus, and therefore it is the least likely part to be able to fit through the cervix.

If we are proceeding in the fashion of a disarticulation D&E, it is quite common in my experience that the skull will be the last portion that we remove. And in order to reduce the diameters, we'll insert grasping forceps into the uterus, often using sonographic guidance to help us as much as possible to locate the skull.

We'll open the instruments wide enough so that they [818] can accommodate the full diameter of the skull, and we will then crush the skull. And after the

contents of the skull have been extruded because of the crushing motion, maintain the skull in the grasp of the instruments and attempt to pull it through the cervix.

Sometimes we can do that in one piece. Sometimes we remove it in several pieces.

Q. The process of incising the base of the skull, is that a blind procedure?

A. No. We do that with direct visualization. The base of the skull is visible at the cervical opening.

Q. And in terms of the dilation process for the D&E's you are doing, at the same gestational age, so, for example, at 20 or 21 weeks, is there any difference in the dilation process that you use between a disarticulation D&E and an intact D&E?

A. We proceed in the same fashion in terms of our approach to laminaria for all of our patients.

While as I said we do prefer intact D&E, we don't know that we are going to do an intact D&E until after it is done. All of our patients get the same approach to dilation using laminaria.

As gestational age advances, the cervix tends to be somewhat softer because of biochemical changes in the cervical collagen and in the fibrous tissue of the cervix.

So as gestation advances, the cervix typically [819] accommodates somewhat more laminaria. And the cervix often has a greater response to the laminaria, and it achieves further dilation.

Q. In your practice or at the practice in the special GYN services where you are supervising the

physicians, how often are you able to achieve an intact delivery in a D&E?

A. I haven't tabulated this, but based on my experience and what my colleagues report after—at or after about 19 weeks gestation, I think we achieve an intact D&E less than half the time. Perhaps it is about one-third of the time.

Q. So would you say it is somewhere between a third and a half?

A. Perhaps. Maybe closer to one-third. In that neighborhood.

Q. And you said that that is beginning at around 19 weeks gestation?

A. Yes.

Q. Does it ever happen that you achieve an intact extraction prior to 19 weeks?

A. Yes, it does.

Q. Dr. Westhoff, do you make it a practice either to effect fetal demise with potassium chloride or KCL or digoxin prior to performing a D&E procedure?

A. It is not my routine practice.

Q. Why is that?

A. That is imposing on the patient an additional procedure [820] which can be difficult to carry out which may, in fact, require me to call in additional colleagues to help with the procedure.

It is not always successful. It carries a small risk of its own complications, and it offers no benefit to my patient.

Q. Can you think of a time in recent memory where you did perform a D&E after fetal demise had been induced with a chemical agent?

A. Yes. The week the PBA ban was signed, and before we knew if we were going to have a TRO, we did arrange to have KCl injection for patients. In particular, a patient I took care of that week had KCl. And in my opinion because of the rapid softening of the fetal tissue it actually made the D&E portion of the procedure more difficult.

And in this particular patient the result was a dismemberment-type of D&E due to the tissue softening. And the patient did, in fact, have some retained tissue, which resulted in infection and required her to have an additional procedure, hospitalization and procedure to empty the uterus after—a couple of weeks after her original D&E. So—

Q. And was the procedure done under ultrasound guidance?

A. Yes, I believe it was, but I don't recall for certain.

Q. And did you do the KCl injection yourself in that case?

A. No, I obtained the KCl injection from—with the assistance of a colleague in maternal fetal medicine in our [821] department.

Q. And why didn't you do the injection yourself?

A. Well, that has not been my practice in the past. I do not at this moment consider myself skilled in doing that. And to maximize the benefit of the patient I wanted to enlist the assistance of someone who is skilled in fetal intracardiac injection.

Q. And in your opinion was the complication of retained tissue correlated with the use of KCl?

MS. CLARK: I will object, lack of foundation. I don't know if there has been established a basis for her to make that correlation judgment.

MS. GARTNER: It was a procedure she did.

THE COURT: This is a procedure she performed; is that correct?

MS. GARTNER: Yes.

THE WITNESS: Yes.

THE COURT: Objection overruled.

THE WITNESS: Well, if I am not—I can't be confident that this would have been an intact D&E without the KCl. But, it could have been. And in my experience, in my opinion the risk of fetal fragments is minimized or perhaps zero when the fetus is intact.

In this particular case, there was definitely fetal softening due to the fetal demise, and so it is clear to me [822] that the fact that this was—did proceed as a disarticulation D&E was because of the extra fetal softening. And that, at least, permitted the occurrence of leaving part of the fetal tissue behind.

But, of course, in the majority of disarticulation cases those complications do not occur.

MS. GARTNER: Your Honor, may I put the chart up?

BY MS. GARTNER:

Q. Dr. Westhoff, I am going to show you a chart which contains the definition of so-called partial-birth abortion as it is stated in the act that is at issue in this

case, and ask you if you want to just refresh your recollection of what it says.

You can just read it to yourself.

Dr. Westhoff, after refreshing your recollection of the definition of the term "partial-birth abortion" in this law, can you tell us whether you fear prosecution under this act for the D&E's that you perform where the fetus is extracted intact?

A. Yes, I do.

Q. Can you explain why that is?

A. In the sort of procedure we were just discussing, I do, in fact, I think, fulfill all the general conditions that are described here, which is that all my actions are deliberate and intentional. The procedure is going forward as a vaginal delivery. The fetus has a heartbeat and is thus living in the [823] case.

And I think skipping for the moment the vertex presentation, in the more common case of breech presentation, much of the fetal trunk, including trunk past the umbilical—the insertion of the umbilical vessels is, in fact, outside the body of the woman.

And at that point I will perform one or more overt acts, such as collapsing the skull and cutting the cord that I know will kill the fetus.

So I think that my carrying out a procedure in this way is a definite violation of the ban, and I would be subject to prosecution.

Q. Dr. Westhoff, do you fear prosecution under this act for the D&E's that you do where the fetus is disarticulated in the course of the evacuation?

A. Yes, I do. The ban itself, the language here does not specify that the fetus must be intact. And there are cases such as we discussed partly a moment ago in which I may first remove a foot or a leg, and then—so I partly dismember the fetus, but then proceed to bring down the breech.

And I believe that would again fulfill the conditions stated in part a of the ban. There are also cases in which perhaps the first part of the fetus I remove might be part of the back or the ribcage, which are, in fact, part of the fetal trunk past the navel.

[824]

And it appears then for me to continue to carry out the D&E would violate the ban as it is stated here.

Q. Thank you, Dr. Westhoff.

Do you ever treat women who present to you in the midst of a spontaneous second-trimester abortion?

A. Yes, I do.

Q. Is that also called a miscarriage spontaneous abortion?

A. Yes, it is.

Q. How do you treat those circumstances?

A. I will proceed to empty the uterus. And a difference from some of the procedures I was describing a few minutes ago is often the woman will need little or no cervical dilation using laminaria.

The cervix may already be soft and may already be dilated, although in some cases the woman will still need laminaria.

The uterus may be infected. The amniotic fluid sac may be ruptured. The fetus may have stopped growing. And other processes are in progress that signal inevitable end of this pregnancy, but it is up to me to actually empty the uterus.

And I would then proceed with emptying the uterus surgically following the same steps that I was describing previously. And, therefore, in those cases, as well, I believe I would be violating the ban as written here.

[825]

MS. GARTNER: Your Honor, I was going to move to one last section. I don't know if you intended to take a break.

THE COURT: Yes. We are going to take a break.

MS. GARTNER: I think I could complete this in 10 minutes.

THE COURT: Why don't we go to 12:00 and start the cross-examination with the defendant after the break?

MS. GARTNER: Okay. Thank you. Your Honor, I would like to approach the witness to give her a copy of the law.

THE COURT: Sure.

MS. GARTNER: This is Exhibit 1. This is a copy of the law that is at issue in the case.

BY MS. GARTNER:

Q. Before we talk about that, Dr. Westhoff, I just wanted to clarify with you: is it your opinion that in doing a disarticulation D&E that it is possible to leave

fetal tissue in the uterus even if the procedure is being performed under ultrasound guidance?

A. Yes, it is.

Q. Okay. Thank you.

Dr. Westhoff, if you could turn to pages S.3-4 of this law. The numbers are on the top of the pages.

A. Got it.

Q. Dr. Westhoff, are you aware of the fact that at the time [826] that Congress passed this law Congress made certain factual findings?

A. Yes, I am aware.

Q. I am going to ask you to look at some of the factual findings that Congress made and tell us whether or not you agree with those particular findings.

If you would look on the page I directed you to, S.3-4, there is a paragraph that starts 14, and then under that there is large A.

A. Yes.

Q. I am going to read that finding to you. It says:

> "Partial-birth abortion poses serious risks to the health of a woman undergoing the procedure. Those risks include, among other things, an increase in a woman's risk of suffering from cervical incompetence, a result of cervical dilation making it impossible"—I am sorry—"making it difficult or impossible for a woman to successfully carry a subsequent pregnancy to term."

I am going to stop there.

If we assume that the procedure that's being referred to here is an intact D&E—let's say assume

that for now—based on your experience do you agree with the statement that intact D&E increases the woman's risk of suffering from cervical incompetence?

[827]

A. I do not agree.

Q. Can you explain briefly why you don't agree with that?

A. And I don't have any personal experience with that complication with relation to my practice, and I am not aware of any literature that has found such an increased risk.

Also, on biological grounds, I think it is implausible. The dilation that we use for D&E is actually less than the dilation that is achieved in an induction abortion, for instance, where the cervix must dilate enough to accommodate the fetal head.

And also, the lesser dilation that we achieve for these procedures is accomplished over a longer period of time than the dilation that occurs during an induction.

So I think compared to the alternatives in the second-trimester, it is implausible that this particular technique would have had greater, if any, damage to the cervix in comparison to the alternatives.

Q. Thank you. Reading on in this paragraph 14a, it states that:

> "Among the risks are an increased risk of uterine rupture, abruption, amniotic fluid embolus, and trauma to the uterus as a result of converting the child to a footling breech position, a procedure which, according to a leading obstetrics textbook,

there are very few, if any, indications for, other [828] than delivery of a second twin."

Do you see that?

A. Yes, I do.

Q. Based on your clinical experience and reading of the medical literature, do you agree that those are risks of intact D&E?

A I do not agree.

Q. Why is that?

A. There are several reasons, including that I have not observed these particular complications in my experience or heard about them.

But, in particular, at nine months the fetus occupies a great deal more space in the uterus, and so the difficulties of doing a version at term alluded to in the obstetrics textbook may not be relevant to what is going on in the midtrimester.

During the midtrimester the fetus is floating more freely in the uterine cavity, and the majority of the time may already be in a breech position or in a transverse position, which is completely different from what occurs at term.

And so therefore it may already be in a breech position, version is not necessary. And if there is a version in the course of the procedure, it is done with a small fetus in a more freely floating environment.

So I think the risks that have been described at [829] term do not apply in this setting.

* * * * *

[830]

* * * * *

What I would like to ask you, Dr. Westhoff, is whether you agree—assuming that this is a reference to intact D&E's—whether you agree that intact D&E lies outside the standard of medical care?

A. No. It lies within the standard of medical care.

Q. Can you explain that?

[831]

A. This is a procedure we carry out, we offer to our patients, carry out and teach safely at Columbia University, as well as a number of other university-based abortion services where it is used and taught, and I think discussed by colleagues and widely accepted among academically-based abortion providers. And, thus, I think it is within the standard of care.

Q. Thank you.

Can you tell us what other academic institutions that you are aware of where intact D&E procedures are being taught and performed?

A. The procedures are being performed—

MS. CLARK: I am just going to object on lack of foundation. I don't know how she knows that these other institutions are or not performing and—

THE COURT: Well, we will limit it to obviously her own personal knowledge.

BY MS. GARTNER:

Q. And, Dr. Westhoff, please, if can you tell me, do you speak with colleagues, fellow OB/GYN's at other institutions around the country?

A. Yes, I do.

Q. Do you speak with them about their abortion practice?

A. Yes, I do.

Q. And based on those conversations and your personal knowledge, can you tell us what other academic institutions are [832] currently teaching intact D&E techniques?

A. Based on specific conversations with colleagues I know the technique is being used and taught at New York University, at Cornell, at Albert Einstein College of Medicine, at Northwestern University, and that it is certainly being taught about in additional medical centers around the country.

Q. Thank you, Dr. Westhoff.

And one final question: if this law were to be enforced, what impact would it have on your practice and on your patients?

A. Well, I would certainly fear prosecution if I were to continue my current practice. And I think it would require conversations between me and our hospital about what the scope—our scope of practice could be in the future.

And there would have to be discussions about discontinuing offering D&E's altogether.

One of my colleagues in another institution right now, since the passage of the law, her hospital has forbidden her from doing any D&E's in that institution.

I would fear that we might be subject to the same change in practice.

* * * * *

[837]

A. Right. Prior to 19 or 20 weeks, because the fetus is much smaller, one day of dilation gives us ample dilation for the completion of the abortion procedure. And because of the larger size of the fetus it requires more dilation at the more advanced gestational age.

Q. So at 19 or 20 weeks you have got two days of dilation, and before that you have one day of dilation?

A. In general. But every case—we do this on an individual basis, based on the patient's anatomy and condition of her cervix, what is most appropriate for that individual.

Q. And you are aware that some physicians prepare the cervix over a three-day period; is that correct?

A. I have heard so, yes.

Q. Now, when you are performing a disarticulation D&E, after you grab the fetal part to be disarticulated, you disarticulate that fetal part by a twisting motion; isn't that right?

A. We use a combination of twisting and traction and—to accomplish the maneuver.

Q. And when you perform an intact D&E procedure, after you grab the fetal part you don't use the twisting motion but instead with a gentle traction you pull the part or parts, and the fetus will emerge through the cervical canal; is that right?

A. Yes, that is reasonable.

Q. When you perform the intact procedure, you perform a * * *.

* * * * *

[838]

* * * * *

Q. And this is not something that is done in a dismemberment procedure, is it?

A. There is a real range in how these procedures occur. And some procedures are completely dismemberment and some procedures are more completely intact. But for many cases [839] there is a range in-between where the fetus is, you could say, partially intact. So there can be some parts, portions of the procedure that occur with dismemberment, and other portions of the procedure that occur intact.

So some of the maneuvers that you are describing right now may still be utilized, in part, during a procedure that is also characterized by dismemberment.

Q. When you do the arm sweeping maneuver, would it be fair to say that when you do this procedure that the fetus would be mostly intact? Would that be the—would that be the situation in which you would do the arm sweeping maneuver?

A. Not necessarily.

Every case really proceeds individually. And to use that maneuver just depends on the relative position of the trunk. And one arm and shoulder at a moment does not depend on whether any of the other parts of the fetus are intact.

Q. Doctor, if you had dismembered the arms, you wouldn't do the sweeping maneuver, would you?

A. If both arms were already dismembered, I would not do the sweeeping, no.

Q. Now, when performing the intact procedure the thorax of the fetus usually will not pass through the cervix without forming this digital arm sweeping maneuver; isn't that correct?

A. I think that is usually correct.

[840]

Q. After you sweep the arms, then the neck of the fetus will be in the cervix, but the head of the fetus will be in the uterus; is that correct?

A. Yes.

Q. And in performing the intact D&E procedure, when the head is still in the uterus, you do not enter the uterus with forceps, but you make an incision with scissors at the base of the skull?

A. My general preference would at that point be to make an incision at the base of the skull, that's right.

Q. And when you are doing the D&E dismemberment procedure you don't make that same incision at the base of the fetus' head. Instead you would decompress the skull by crushing it, correct?

A. That is generally correct, yes.

Q. Is it correct that at the Allen Pavilion, that—is it correct that at the Allen Pavilion you have been performing abortions there for the last three years?

A. Yes, we perform some abortions there. In years from the mid-90's forward. But the service as I described it has existed at the Allen Pavilion since 2001. But there were abortions performed there, you know, in lesser numbers in years preceding 2000.

From about 1995 forward there were certainly some abortions performed at the Allen Pavilion. Maybe one half day a week or one day a week in the preceding years.

* * * * *

[843]

Q. But you would agree, wouldn't you, that if you wanted to you could dilate the cervix so much that you didn't have to crush the head?

A. Well, for instance, with an induction, the cervix will dilate more, and the head will be delivered without reducing its diameters.

I have never done this, but I imagine it would be possible to continue using laminaria for additional serial treatments over time and achieve greater dilation to the point where the cervix is as far dilated as the diameter of the fetal head.

So I have never done that, so I can't say for sure.

Q. Doctor, if you wanted to determine the safety of intact D&E versus a dismemberment D&E in terms of cervical incompetence, at a minimum you would need to follow the women through their next pregnancy; isn't that right?

A. Since cervical incompetence is, in fact, determined by outcome of the future pregnancy, you don't have outcomes until the women have another pregnancy.

Q. So you would have to follow women into their next pregnancy—

A. Right.

Q. —in order to make a determination?

A. Yes, given that not all women are going to be having a future pregnancy, you can only follow the subset that does have [844] a future pregnancy.

Q. And at this time, you do not know what the results of a study comparing the long-term complication of cervical incompetence would be if you compared dismemberment D&E to intact D&E; isn't that right?

A. I am sorry. Can I hear that one more time?

Q. At this time you don't know what the results of a study would be of comparing dismemberment D&E and intact D&E with respect to cervical incompetence; isn't that right?

A. I do not know the results of a study that has not yet been done, that's correct.

Q. And, Doctor, in performing a reliable study you would want to follow all the patients through the next pregnancy, not some of them; isn't that correct?

A. I am just pondering if I can find a different word than "reliable," because "reliable" means in really epidemiological terms is if you do a study once, for instance, and you do a study a second time and you get the same results the second time, then you have done a reliable study. And I don't think that is what you are actually asking me.

Q. If you do one study.

A. One and only one study.

I would like to get the most information from a study, if you have outcome information on the largest proportion of subjects. And so I would—in doing any study, [845] I would like to have as much outcome

information as possible in order to learn something from the results.

Q. So you would prefer to evaluate all of the women who had a subsequent pregnancy, who had subsequent pregnancies, rather than only some of them when evaluating cervical incompetence?

A. If it is possible to get that information that would be valuable information to have.

Q. Now, you stated in your November 4th, 2003 declaration submitted in connection with the New York case that you do not believe intact D&E would cause cervical incompetence; is that right?

A. That's right.

Q. And your belief that D&X or intact D&E would not lead to cervical incompetence is simply a belief, right?

A. There are not at this point very much data, so I am basing that more on my kind of interpretation of the biology of what happens more than on the results of studies, which, as you know, have not yet been done to any large degree.

Q. And as an epidemiologist, you don't give much weight to someone's belief in the total absence of studies, do you?

A. Well, in fact, in epidemiology there is certainly a hierarchy. And clinical experience and biological plausibility certainly do inform practice in my understanding of the world.

If I have studies, I would be more inclined to rely on results of the study than to rely on belief that exists just [846] in my own head, certainly.

Q. And in the field of epidemiology, intuition is not accepted as a valid method of proof or analysis, is it?

A. If one is looking at a study, you use statistical methods to analyze the study. You don't use intuition to analyze the study.

But if there is no study at all, one must rely on biological principles and clinical experience in order to formalize a basis for practice.

Q. But in the field of epidemiology, intuition is not accepted as a valid method for proof and analysis, is it?

A. If one is analyzing a study, one needs a statistical, analytical method. One doesn't use intuition to analyze the results of a study.

Q. It is correct that you performed D&E's by disarticulation at 23 weeks; isn't that right?

A. I have done so, yes.

Q. And in your opinion, a disarticulation procedure at 23 weeks is safe?

A. It is safe.

Q. And it is safe at 21 weeks?

A. Yes. Safety is always relative to what the alternatives are. And safe in the sense that the overall complication rates are low, but one must also think what the alternatives are.

Q. Doctor, you do not take steps to ensure that the fetus is * * *.

[847]

* * * * *

Q. Doctor, you do not set out to take steps to ensure that a fetus is removed intact because of maternal complications, right?

A. In general with D&E's I do prefer to remove the fetus intact if I can safely complete the procedure that way. And as I stated earlier, we don't do intact procedure for more than half of our patients, so that is not always possible.

I do think my patients with medical problems have more to benefit from an intact approach, but it doesn't—the fact that they have the potential to benefit the most from an intact approach doesn't necessarily mean that I am more capable of achieving an intact approach in those patients.

I may still do a dismemberment approach because at the time of the procedure that's the safest thing I am able to accomplish.

* * * * *

[861]

* * * * *

Q. And the Chasen study found no difference between the time of the procedure for the women in the intact group and the women in the dismemberment group; isn't that right?

A. Well, I disagree slightly with that characterization of the results in table III at median procedure time. So what they find is that the 50th percentile is 22 minutes in each group. But you will see that they also give the range. And in the intact group, the longest procedure was 45 minutes. But in the disarticulation D&E group, the longest procedure was 60 minutes.

It is the longest procedure which is really an indicator of what is happening and also difficult procedure. You can see for both types the shortest procedures were six minutes. The median procedure was 22 minutes. But there was a difference in the longer procedure. And they chose to present their results as a comparison of medians, which is fair and reasonable thing to do.

But what concerns me with taking care of patients is how long does the hardest procedure take? And that was longer in disarticulation group.

Q. And, Doctor, for what may be the one procedure that took the 45—that took the 60 minutes, you have no idea what the circumstances were surrounding that patient, do you?

A. You're right. They did not present the data surrounding [862] that.

Q. And so it is important—what is important to report is the median—is the median length of time to perform the procedure; isn't that correct?

A. I think there is really a legitimate variety of ways to report outcomes, and averages are one of them. I think averages can be reported as means or medians, for instance.

I think it's legitimate to know how long are the longest, most difficult procedures. There are a variety of things. They chose to present one. And the one they chose to present is perfectly legitimate. But I was interested in reading this at looking at how long the longest procedures took.

Q. And you also testified that there are advantages of the intact D&E procedure, and that it helps minimize blood loss, correct?

A. Yes, I did.

Q. And you testified earlier, the Chasen study found no difference in the blood loss between the woman in the intact group and the woman in the dismemberment group, right?

A. Yes. Similarity, again, in table III, they reported the medians. And the medians are exactly the same. And for both cases the ranges are a little different with the intact group having a range from 20 to 1200 CC's of blood, and the disarticulation group having a range from 40 to [863] 1500 milliliters of blood.

So the disarticulation group, also, the worst patient had 300 ML's more of blood loss or one unit additional blood loss compared to the intact group.

* * * * *

[865]

Q. And I think you testified in answer to one of Ms. Clark's questions that in your opinion intact D&E would be especially beneficial for women with maternal health conditions; is that correct?

A. Yes, I think so.

Q. Can you explain why that is?

A. Well, if a woman has a serious medical problem at the time she begins her care, she is—will be vulnerable. And if that woman experiences a complication, that complication in her case may be catastrophic compared to a woman who goes to have a D&E without preexisting medical problems.

And it is simply that, for instance, a perforation or laceration or heavy bleeding will require additional interventions. And the woman who starts the case with medical problems simply doesn't have the stable condition and physiologic reserve to cope with the complication. So avoiding major complications is particularly important for that woman's health.

* * * * *

Supreme Court, U.S.
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No. 05-1382

In the Supreme Court of the United States

ALBERTO R. GONZALES, ATTORNEY GENERAL,
PETITIONER

v.

PLANNED PARENTHOOD FEDERATION OF AMERICA,
INC., ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

JOINT APPENDIX
(VOLUME 3)

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PETITION FOR A WRIT OF CERTIORARI FILED: MAY 1, 2006
CERTIORARI GRANTED: JUNE 19, 2006

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UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C 03-4872 PJH

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. AND PLANNED PARENTHOOD GOLDEN GATE, PLAINTIFFS

v.

JOHN ASHCROFT, ATTORNEY GENERAL OF THE UNITED STATES, IN HIS OFFICIAL CAPACITY, DEFENDANT

TRANSCRIPT OF PROCEEDINGS
Friday, Apr. 16, 2004
Volume 11

BEFORE THE HONORABLE
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* * * * *

[STEPHEN T. CHASEN, M.D.—DIRECT EXAMINATION]

[1705]

* * * * *

Q. Good morning, Dr. Chasen.

A. Good morning.

Q. Are you a physician?

A. Yes, I am.

Q. And what are your specialties?

A. I'm an Obstetrician and Gynecologist, and my subspecialty is maternal fetal medicine.

Q. Are you board certified in those areas?

A. I am board certified in both areas, yes.

Q. Where are you currently employed?

A. I am a member of the full-time faculty of the Weill Medical College of Cornell University.

Q. And where is the Weill Medical College, Cornell, located?

A. In New York City, Manhattan.

[1706]

Q. What position do you hold there?

A. I am an associate Professor of Obstetrics and Gynecology.

Q. Do you have any other medical appointments?

A. I have privileges at hospitals. That's my academic appointment is at the medical college. I am an attending physician at the New York Weill Cornell medical center, which is the teaching hospital of the Weill Medical College of Cornell University.

And I am also—I also have privileges at Flushing Hospital and Medical Center in Queens in New York City.

Q. What position do you hold at New York Weill Cornell Medical Center?

A. I am Director of High Risk Obstetrics. I am the co-director of the Obstetrics and Gynecology residency program, and I am the director of the maternal fetal medicine fellowship program.

Q. Are you in the same department as Dr. Carolyn Westhoff?

A. No, I am not.

Q. What are your responsibilities in your positions at the New York Weill Cornell Medical Center?

A. My clinical responsibilities include being the attending and responsible physician for the high risk obstetrics clinic where women who have—they may have medical problems that precede pregnancy or medical patients who receive prenatal care at the high risk obstetrics clinic. Some of these patients [1707] have medical problems that precede pregnancy. Some have complications that arrive during pregnancy. Some of these patients are found to be carrying fetuses that are abnormal.

And these—all of these women receive prenatal care under my direct supervision at our high risk obstetrics clinic.

My clinical responsibilities also include supervising the care of women who are pregnant and are hospitalized for reasons not having to do with delivering a baby.

Again, various complications may include preterm labor or other medical problems. My clinical responsibilities include supervising the prenatal diagnosis unit where women may come to have ultrasound while they are pregnant or to have procedures such as amniocentesis or other types of prenatal diagnostic procedures or assessments of fetal health.

I also see women as outpatients for whom I am not providing prenatal care, but as a consultant, women who may be planning to get pregnant, who may have a

complicated reproductive history or may have medical problems that could complicate pregnancy or who are found to have—to be carrying a fetus that is abnormal in some way.

Those are my main clinical responsibilities.

Q. In what settings do you currently treat patients?

A. I treat inpatients in the hospital. I treat outpatients in [1708] the high risk obstetrics clinic, patients who are receiving prenatal care.

And I see outpatients in the prenatal diagnosis unit for women, again, who are coming for prenatal diagnosis or women who are coming to see me as a consultant.

Q. And approximately how many patients are currently under your care?

A. The patients under my direct prenatal care are those patients in the high risk obstetric clinic. And at any given time I believe we are following approximately 50 patients.

At any given time I am probably supervising the care for anywhere from one to five inpatients, pregnant women with complications requiring prenatal admission to the hospital. And our prenatal diagnosis unit has an extraordinary high volume. Every day, probably, between 50 and 80 women come for a procedure, whether it's ultrasound or invasive procedure. So I don't see all of those women personally, but I supervise and I oversee their care.

And in any given week I probably see between five and ten women who come to see me in consultation.

Q. What is the range of gynecological and obstetric care and counseling that you provide?

A. All matters of obstetric procedures, including prenatal care, including prenatal care in both inpatient and outpatient setting, prenatal diagnosis. I do have some labor and delivery [1709] coverage responsibilities where I have the opportunity to deliver babies by vaginal delivery or by c-section. Surgical procedures that I do that aren't c-section. Most women these days require vaginal deliveries that have a surgical procedure could include a procedure called "cervical cerclage," whereby a stitch is placed around the cervix with the intent of preventing a pre-term birth.

And another procedure I do is abortion, almost all of which are in the second-trimester.

Q. And why are most of the abortions you perform in the second-trimester?

A. Almost all cases of abortion I perform follow the prenatal diagnosis of a certain abnormality. Unfortunately, such prenatal diagnosis don't occur in the first-trimester. They occur in the second-trimester.

I do some cases for women who have medical complications in pregnancy. And the physiology in pregnancy is such that most of these conditions will become manifest or deteriorate after the first-trimester.

And the final reason is that in my hospital, in my department, there are only a few of us that have the expertise to perform second-trimester surgical abortion. Most obstetricians in my department are comfortable doing first-trimester abortion. So those patients are not referred to me.

[1710]

Q. Approximately how many abortions do you perform a month?

A. Usually between three and five.

Q. And up to what gestational age do you perform abortions?

A. In a living fetus—again, I do some abortions following spontaneous fetal death. In a living fetus up to 23 and six-seventh weeks.

Q. Is that 23 and six-sevenths weeks LMP?

A. It's 23 and six-sevenths weeks LMP to correspond to, I guess, 21 and six-sevenths weeks postconception.

Q. And what type of second-trimester abortions do you perform?

A. I perform dilation and evacuation.

Q. And is dilation and evacuation procedures been a significant part of your abortion practice?

A. Given that essentially all of the abortions I perform are in the second-trimester and almost all of them are surgical abortion, dilation and evacuation is the procedure I perform in almost all cases.

Q. Have you also performed induction abortions in the second-trimester?

A. I have.

Q. Have you ever performed what has been called an intact D&E?

A. I perform D&E, and one of the variations that I use includes what is required as an intact D&E.

Q. Is the intact D&E variation a significant or a part of your regular practice?

[1711]

A. Yes, it is.

Q. Is it a significant part?

A. Yes, it is.

Q. You also indicated that you teach at Weill Medical College at Cornell; is that right?

A. That is correct.

Q. What subjects do you teach?

A. I teach obstetrics, both low risk and high risk. And I teach that to medical students, as well as residents in obstetrics and gynecology. I teach high risk obstetrics to residents and obstetrics and gynecology and to physicians who have completed a residency in OB/GYN and are doing a fellowship in maternal fetal medicine.

I teach prenatal diagnosis to residents and to maternal fetal medicine fellows. I teach hands-on procedures like deliveries or cerclages or abortions to medical students, residents and fellows at the medical college.

Q. And does your institution offer any training in abortion procedures?

A. Yes, it does.

Q. What types?

A. Medical abortion in the first and second-trimester, and surgical abortion in first and second-trimester.

Q. Does your institutional also teach induction abortions?

A. Yes, it does.

[1712]

Q. And is D&E procedure taught?

A. Yes, it is.

Q. Is the intact variation of D&E taught at your institution?

A. Yes, it is.

Q. And to how many medical students or residents are abortion procedures taught?

A. The medical students rotate through an Ob/Gyn department in the third year of medical school. There are approximately 100 students a year, all of whom will rotate through our department and all of whom will have the opportunity to observe and participate in procedures, including surgical abortion.

There are 25 residents in our residency program, and they all rotate periodically through the gynecology service, including procedures in the operating room. And the vast majority of these residents participate in abortion procedures.

Q. Do you have any responsibilities for training these residents?

A. Yes, I do. I have a large responsibility in training these residents.

Q. What is that, roughly?

A. I am the co-director of the residency program, so I am one of the responsible physicians for their education, both in the clinical setting, as well as in the

didactic setting. I have a huge administrative responsibility for scheduling and things like that.

[1713]

And in almost all of my clinical activities in all of the settings I have described I frequently have residents with me who are observing and learning, whether it's ultrasound or counseling, or providing prenatal care in labor and delivery and in the operating room.

Q. Do you supervise a fellowship?

A. Yes, I do.

Q. What is that fellowship?

A. That is the maternal fetal medicine fellowship.

Q. How does your time divide between teaching and your other responsibilities?

A. Well, in almost all of my clinical responsibilities, as I have stated, does involve teaching. So there is a very, very, very small portion of my activity that doesn't involve some teaching.

Purely didactic teaching where I have a group of residents and students or fellows in a lecture room and giving a presentation may account for 10 percent of my time. Probably another 10 percent of my time is in the administrative and research. And probably the other 80 percent of my time is devoted to clinical activity. But, again, teaching is a part of most of this activity.

Q. Do you serve on any hospital committees?

A. Yes, I do.

Q. What are those?

[1714]

A. I am a member of the Quality Assurance Committee for the Department of Obstetrics and Gynecology. This committee is charged with reviewing the medical care of patients that may have had complications or whose records have been referred to my committee for review. It could arise from a patient complaint or a complaint from a physician or another health care professional.

And this committee reviews the medical care and makes recommendations to the hospital Quality Assurance Committee and to the chairman of my department.

I am also a member of the Obstetrics Patient Safety Committee for the hospital. And this committee is charged with reviewing protocols and developing and implementing protocols relating to obstetric care to maximize patient safety and to anticipate and avoid complications in our patients.

Q. Are you also a member of any professional associations?

A. I am. I am a fellow of the American College of Obstetrics and Gynecology, or ACOG. And I am a member of the Society for Maternal Fetal Medicine.

Q. Have you authored any publications?

A. Yes, I have.

Q. Approximately how many?

A. I have authored or co-authored approximately 30 articles in literature, all but two or three of which underwent peer review.

[1715]

Q. In what subjects were those articles?

A. They really comprise the whole breadth of obstetrics. Some of them relate to medical or obstetric complications in pregnancy, multi-fetal pregnancy: twins and triplets, prenatal diagnosis of—based on abnormal ultrasound, prenatal diagnosis of downs syndrome, genetic—other genetic abnormalities in pregnancy, as well as abortion.

Q. Do you sometimes perform peer review for journals?

A. I do.

Q. For which journals?

A. I am a peer reviewer for the American Journal of Obstetrics and Gynecology, which we call the Gray Journal.

I am a peer reviewer for Obstetrics and Gynecology, which we call the Green Journal, the Journal of Maternal Fetal Medicine, the American Journal of Perinatology, and the International Journal of Gynecology and Obstetrics, and some other journals that have various permutations of all of those names.

Q. Have you received any honors or awards for teaching?

A. I have. Every year the graduating chief residents in our Obstetrics and Gynecology program recognize a faculty member for teaching. And I have received that award on three occasions: in 1998 and 2001 and 2003.

MS. PARKER: Your honor, may I approach the witness?

THE COURT: Yes.

[1716]

BY MS. PARKER:

Q. Dr. Chasen, I show you what has been marked as plaintiffs' Exhibit 24. Do you see that?

A. Yes.

Q. Is that a copy of your C.V.?

A. Yes, it is.

Q. Is it true and correct?

A. Yes, it is.

Q. And is it current?

A. It is.

MS. PARKER: Your Honor, I would like to offer Exhibit 24 into evidence.

THE COURT: Any objection?

MS. PARKER: Actually, I might note that the Exhibit 24 in the binder contained his expert report, because that was how it was introduced at the deposition, but we are only seeking to introduce the several pages that constitute his C.V.

THE COURT: Let me make sure I have that. Is it titled "Biographical Sketch"?

THE WITNESS: Yes.

THE COURT: All right. I have that. Any objection?

MR. QUINLIVAN: Subject to Ms. Parker's qualification that they are only seeking those three pages, we [1717] have no objection.

THE COURT: Those will be are taken apart from the other attachments.

MS. PARKER: We have done that with the formal exhibit, your honor.

THE COURT: Admitted.

THE CLERK: Twenty-four into evidence.

(Plaintiffs' Exhibit 24

was received in evidence.)

MS. PARKER: At this time, your Honor, we tender Dr. Chasen as an expert in obstetrics and gynecology, maternal fetal medicine and abortion practice and procedures pursuant to the federal rule of evidence 702.

THE COURT: Any objection?

MR. QUINLIVAN: No objection, your honor.

THE COURT: Any request to voir dire?

MR. QUINLIVAN: No.

THE COURT: All right. He will be accepted as qualified in those areas.

BY MS. PARKER:

Q. Dr. Chasen, you indicated that the majority of abortions you perform in the second-trimester are D&E's; is that right?

A. That is correct.

Q. What is your goal when you perform a D&E?

A. The overall goal is to end the pregnancy, which involves [1718] removing the fetus and the placenta from the uterus and to do so in a way to minimize the risk of complications to my patients.

Q. Could you describe briefly how you do the dilation portion of the D&E procedure?

A. The dilation portion of the procedure is a component of almost all of the procedures I do. There are some patients that I treat that may have conditions that almost invariably lead to spontaneous abortion or very, very, very premature labor.

These patients may present with advanced degrees of cervical dilation. So in these cases I don't do—I don't do this dilation procedure that I am about to describe.

But in the vast majority of patients the dilation procedure—I do the dilation procedure that involves placing the laminaria in the cervical canal. And depending on the gestational age, primarily, that will dictate whether I—how many placements of laminaria I will use.

Q. How many sets of laminaria do you typically use?

A. Broadly, with some exceptions, again, prior to 20 weeks in almost all cases I will use a single set of laminaria. in almost all cases after 20 weeks, I will do—I will do two sets of laminaria.

Q. What is the maximum number of laminaria that you typically use in your first set?

[1719]

A. In the first set—and, again, my goal in placing laminaria is to place as many as will fit in the cervix without forcing it in there. And this can depend on factors. The biggest factor is para of the patient. Women that have had a cervix dilate usually under happier circumstances, like in labor, their cervixes can be a bit more laminaria.

But, in general, with the first set of laminaria, which may be the only set in some patients, anywhere from two or three up to six.

Q. And when you do a second set—first, how far after—how many hours after the first set do you typically put in the second set?

A. In most patients who are outpatients I will typically do them 24 hours apart. In certain circumstances I can compress that time.

Q. How many do you generally insert in the second set of laminaria?

A. In most cases I will insert between eight and twelve. Laminaria come in different sizes. So the laminaria I will insert on the second insertion are bigger than the ones I will insert on the first insertion. But in most cases, eight to twelve.

Q. Have you ever had a patient become infected as a result of the insertion of laminaria?

A. The only case that I can recall involved a patient who was [1720] undergoing D&E because of the preterm premature rupture of membranes, or PPROM.

This patient was undergoing D&E precisely because she had some evidence of infection already. She had clear evidence of infection after laminaria insertion, but I think the infection preceded the laminaria insertion.

No patient who didn't have this condition have I seen an infection due to laminaria.

I start all patients on antibiotics on the day that I insert laminaria.

Q. Can you briefly describe the evacuation part of the D&E procedure?

A. Yes. I will try to do it briefly. The day after the last laminaria insertion, which before 20 weeks is usually the first and only laminaria insertion, patients arrive in the hospital. They are taken to the operating room.

After answering a whole lot of questions from nurses and anesthesiologists, they lie down. They receive an intravenous line. They receive anesthesia. And, again, at the discretion of the anesthesiologist, they will receive general anesthesia or they may receive sedation, intravenous sedation that is short of general anesthesia, but usually those patients are asleep, as well.

They are placed in stirrups. I remove the laminaria. Then, they receive a sterile wash. Sterile drapes [1721] are placed. The bladder is drained with a catheter.

And under anesthesia—once I have scrubbed and put on a sterile gown and gloves, I will do an examination under anesthesia, and sometimes, ultrasound as well.

At which time I will determine the degree of cervical dilation, the degree of cervical effacement or how thick—how long the cervix is, the proximity of the cervical opening to the vaginal opening, which can vary primarily based on whether women have gone through labor and had their pelvic muscles stretched before, the position of the fetus.

I can ascertain usually through a digital examination, but with ultrasound that I have, as well, in some cases. And I make a determination about what

the safest—at that time I determine what the safest way is to remove the fetus.

Q. And do you prepare a patient differently depending on what procedure you are considering doing?

A. The procedure in all cases is the D&E. Some variations of D&E that we will talk about, the intact D&E or the disarticulation with forceps, I don't prepare patients any differently, because, again, I don't determine what the appropriate technique or variation of D&E will be until the patient is under anesthesia and I examine them.

Q. How do you proceed at that point after you have done the assessment?

* * * * *

[1722]

A. After the assessment, if I think circumstances are such that—and, again, my goal is to remove the fetus with as little disarticulation as possible with forceps, and if possible, with no disarticulation with forceps or no introduction of forceps into the uterine cavity.

Q. Slow down.

A. So, if again, circumstances permit, I will proceed with a manual breech extraction of the fetus. And I will proceed with a breech extraction. In most cases the head will become lodged at the cervix. And in those cases I will typically make an incision with the scissors under direct visualization, because the base of the skull is in the cervix, and I can see it in almost all cases.

I make an incision, introduce suction, aspirate the contents of the brain tissue. And at that point, the size of the fetal head is decreased to the point where it will pass easily through the cervix.

In cases where I don't feel I can do a manual breech extraction, then I will proceed with forceps. In some cases I can, with the first pass of the forcep, remove one or both legs of the fetus from the uterus into the vagina without disarticulation. And in those cases I then can proceed with a breech extraction, as I have described before.

In most cases where I need to proceed with forceps, I will have to complete the case or remove the fetus with [1723] disarticulation. But my goal is to do as little disarticulation as possible and remove the fetus as intact as I can.

Q. At what time during the procedure do you decide whether to proceed with forceps or to do a manual extraction?

A. That's after I have done an examination under anesthesia. That's when I decide the safest way to proceed.

Q. Do you do more dilation for a patient when you are able to do the manual extraction?

A. The preoperative dilation or dilation portion is identical in all patients, and primarily that is based on the gestational age. In cases in which I am able to do an intact—the intact variation of D&E, those patients tend to have more dilation than patients in whom I must resort to forceps.

Q. So what factors influence which of the two approaches you will use?

A. Again, probably the most important, but certainly not the only factor is the degree of cervical dilation that is achieved. And it's achieved in most cases with laminaria. But other factors can include the effacement, or how long the cervix is. And, again, a lot of that relates to whether or not women have been through labor before.

Women who haven't been through labor before tend to have a cervix that may be considerably longer, which can make it difficult to do a breech extraction. The degree of [1724] relaxation of the pelvic floor can play a big role.

Women who have gone through labor before tend to have their pelvic floor muscles stretched, and the cervix maybe quite a bit closer to the vaginal opening, so my hand or a forcep does not need to travel as far to grasp the fetus and hopefully to do a breech extraction.

The position of the fetus plays a role in if it is in a breech presentation—and nearly half of the fetuses inthis gestational age may be—the lower extremities may be right above the cervix and may be easier to grasp.

If the fetus is presenting head first or transversely, then the lower extremities are not as accessible, either manually or with forceps. And some in some cases there is more room for manipulation within the uterus than in other cases.

And this can kind of depend on the volume of amniotic fluid and the degree of relaxation of the uterus. It tends to be more relaxed in a woman who has had labor before compared to a woman for whom it may be the first pregnancy.

So these are—there is no formula. These are all the factors I take into account.

Q. Do you convert the lie or the position of the fetus to achieve manual extraction?

A. Yes. Yes, I do.

Q. And how do you do that?

[1725]

A. In some cases, again, based on the factors that I have told you, in some cases I am able to, if all the factors I described in my prior answer are favorable, I can actually reach into the uterus and with my hands grasp one or both of the lower extremities and do it manually.

I have my other hand on the abdomen, and I can externally, by pressure on the abdomen also, try to turn the fetus in concert with the hand. Or in some cases a forcep in the uterus and ultrasound guidance is sometimes helpful in doing this podalic version.

Q. At what gestational ages do you typically perform the intact variation of D&E?

A. In most cases, but not all, it will be at or after 20 weeks.

Q. And do you sometimes remove an intact fetus earlier than 20 weeks?

A. In some cases I do.

Q. How early have you been able to do that?

A. I have done it as early as 14 or 15 weeks, I believe.

Q. Do you have a preference as to whether you're able to remove the fetus intact?

A. My preference is to remove a fetus with as little intervention as possible and with as little manipulation with forceps. Every time I insert a forcep into the uterine cavity I have the capacity to cause uterine rupture which ultrasound [1726] can't completely prevent. Every time of open the forcep with the intent of grasping the fetus, I can't be certain that I am not also grasping the wall of the uterus. And, again, ultrasound cannot always identify those cases.

So, my answer is that it's always with as little intervention with forceps as possible to remove the fetus, and with as little disarticulation, and preferably with none.

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[1730]

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Q. What conclusions did the study draw?

A. The primary conclusion or one primary conclusion was that the rate of spontaneous pre-term birth in this group of women who got pregnant following D&E was six and a half percent. And that that was consistent with the overall rate of spontaneous—consistent with the overall rate of spontaneous pre-term birth that we see in our hospital and that has been [1731] described nationally.

Another outcome that we looked at was the gestational age at which these women underwent abortion and how far the cervix was dilated at the time they underwent surgical abortion to see if this had any impact on the rate of spontaneous pre-term birth in their subsequent pregnancy.

And what we found was that in women that had D&E between 14 and 24 weeks, we actually found the trend towards lower rates of pre-term birth in women that had D&E in these later gestational periods within that interval. And when we looked further, we found a correlation, an inverse correlation, between preoperative cervical dilation and the rate of spontaneous preterm birth.

In other words, that the more cervical dilation was achieved prior it surgical evacuation, the D&E procedure, the lower risk, the risk of pre-term birth in the subsequent pregnancy was lower compared to women who had lesser degrees of cervical dilation in their D&E procedure.

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[17:33]

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Q. Did your study have any implications about the impact of second-trimester D&E on cervical incompetence?

A. Cervical incompetence, that is a terrible term to use especially in front of the patient, because they take it personal. But, we can say "cervical insufficiency."

But, anyway, this term implies a propensity for the cervix to dilate painlessly or not under the influence of labor contraction in the uterus. And this is a risk factor for a miscarriage in the second-trimester or preterm birth, as well.

And to the extent that D&E could or surgical abortion could damage the cervix and could predispose to this condition, we would be concerned. And, again, we didn't see this in the study. And the low rates of

spontaneous pre-term birth we saw in the whole cohort as a whole were even lower in those in whom the cervix was dilated more and at later gestational ages.

So to the extent that anyone could be concerned that osmotic dilation of the cervix with laminaria is something that could damage the cervix and predispose to cervical incompetence or pre-term birth, I think the study suggests that the opposite [1734] is true.

* * * * *

[1735]

Q. So Dr. Chasen, now I would like to talk to you about another study that you performed.

MS. PARKER: Your Honor, can I approach the witness?

BY MS. PARKER:

Q. Dr. Chasen, I have handed you Plaintiffs' Exhibit 19, which is an article called "Dilation and Evacuation at or Equal to—Greater Than or Equal to 20 Weeks: Comparison of Operative Techniques." Do you see that?

A. Yes, I do.

Q. And has Exhibit 19 been accepted for publication?

A. It has been accepted for publication. It's in press for the American Journal of Obstetrics and Gynecology. These are the uncorrected proofs. The published version is almost identical to these uncorrected proofs.

Q. Right. And I neglected to note that it is copyrighted 2004 by Elsevier.

When is it scheduled for publication?

A. I believe, according to the publisher, the May edition of this year.

Q. What journal is it going to be published in?

A. The Gray Journal: American Journal of Obstetrics and Gynecology.

Q. What was the objective of the study that is described in this article?

A. The objective of the study was to look at women having D&E [1736] late in the second-trimester, at 20 weeks and beyond, and looks—and specifically divide them into two cohorts: women who had D&E with dismemberment with forceps versus women who had D&E with the variation we will call "intact extraction" or "intact D&E." And to compare outcomes, including complication rates from D&E. And a secondary objective was to look at subsequent pregnancy outcomes in these two cohorts of women.

Q. Whose idea was it to conduct the study?

A. It was my idea to conduct the study.

Q. What was your role on the study?

A. I was the principal investigator. I conceived of the study. I sought and received permission from the Institutional Review Board to conduct this retrospective study.

I designed the data sheet that my co-investigator—that some of my co-investigators would use to extract data from patient medical records.

I designed the database in which data would be entered. I did the statistical analysis myself. I wrote and revised the manuscript myself with appropriate input from my co-authors.

Q. Why did you conduct the study?

A. I conducted the study—and, again, this is true for all the studies that I have conducted and published in my career. I conducted the study, really, because to answer a question or questions. Any study that is out there that can be and should [17:37] be published, really, is to address a gap in medical knowledge that is in the literature.

There can be topics for which there aren't any published studies. There can be topics for which there are conflicting data.

This specific study the question, the medical question which, I think, unfortunately has boiled over into a legislative and judicial controversy, regards the safety of different variations of D&E that are used.

And there are medical questions which I'm primarily interested in about the safety of these different variations of D&E. Of course, others are interested in other forums for other reasons.

But it was really to answer questions that are, indeed, medical controversies and looking at our data, sharing our data in the peer review literature, to fill in, I think, what is—what most people would agree is a gap in the peer review literature.

Q. Did you conduct the study for this litigation?

A. I did not.

Q. Were there any preexisting published data comparing the safety of the two variants of D&E?

A. Not that I am aware of. Not that anyone that I know of is aware of, so I would answer: no.

* * * * *

[1739]

* * * * *

Q. And you indicated you examined two different variants of D&E. So did you distinguish between them for purposes of this study?

A. Yes, we did.

Q. What did you call the two variants in the study?

A. It underwent an evolution in different versions of the manuscript. The first version mirrors my clinical practice and how I describe these things. That there was—the two variations were D&E with disarticulation and D&E with intact extraction.

As this went through peer review, it was suggested that we—that that was a little verbose and that we talk about—we use the term that ACOG had used "intact dilation and extraction," or "D&X."

So I think the second version talked about D&E, dilation and evacuation and dilation and extraction. And in the final variation, which is the one that will be published, we added the word "intact" in front of—before "dilation and extraction," just to create more of a contrast for the readers.

There was dilation and evacuation and intact dilation and extraction.

But based on the title of the study and based on the [1740] introduction, it is very clear that these were all D&E procedures and they were dealing with two variations.

Q. And how did you distinguish between the intact and disarticulation procedures when you were reviewing the medical records?

A. Well, we reviewed the operative reports. And at our teaching institution, in most cases residents or fellows will dictate their operative reports, and usually they will really dictate everything in using a lot of detail. So we were able to differentiate, primarily, by looking at the dictated operative reports which technique was used.

* * * * *

[1745]

Q. What did your study conclude?

A. Our study concluded that in these women late in the second-trimester undergoing D&E that the overall rate of complications, most of which were minor, was 5 percent, and that there was no significant difference in the complication rate between those women undergoing D&E with intact extraction compared to those women undergoing D&E with disarticulation.

Q. Now, you indicated the rate was 5 percent overall? What was the complication rate for the D&E's analyzed in both groups?

A. It was 4.9 percent, or I think 13 out of 263 for the D&E with disarticulation, compared with 4.9 percent compared with 5.0 percent or six out of 120 in women undergoing D&E with intact extraction.

Q. What does the complication rate of roughly 5 percent reveal about both of these variations of D&E?

A. I think it reveals that these—especially given that almost all of the—that all but three of these complications would be considered minor, this is a—that these are safe.

Both variations of D&E should be considered safe.

Q. How many complications were reported in the study?

A. Total of 19.

Q. What kind of complications did you observe?

A. I think more than half of the complications were genital tract lacerations. I think most of those were cervical—[1746] superficial cervical lacerations, really, at the site of the tenaculum or the clamp that holds the cervix in place. There were some lacerations involving the labia, I think.

There were other complications. They included a few patients that needed curettage after they went to the recovery room. A couple patients who got readmitted for having bleeding and required curettage. And there were three severe complications.

Q. So there was three severe complications out of 383 patients?

A. That's right.

Q. And what were those?

A. These three complications; one woman had uterine perforation, and she unfortunately required a hysterectomy.

One woman had an amniotic fluid embolism, and she was admitted to the intensive care unit, and she required transfusion of blood and blood products.

And another woman had a disseminated body wide infection and sepsis, which was a life-threatening condition, and she required admission to the intensive care unit.

And during that admission, she was also diagnosed with pulmonary embolism, which is a blood

clot that lodges in the blood vessels and in the lung, which is also a life-threatening complication.

Q. And what variant of D&E did the three women who experienced [1747] the severe complications have?

A. All three of these women had D&E with disarticulation.

Q. Did you find that the difference in terms of severe complications between the two variants at a level of statistical significance?

A. No. It was a 1.1 percent rate of severe complications in the women who had D&E with disarticulation compared to 0 percent, none, in the women who had D&E with intact extraction. But that did not approach the level of statistical significance.

Q. Were there differences in the demographics of the two groups, patients that were in the study?

A. There were some important differences in the demographics.

Starting with the indication for having the procedure, a significantly higher proportion of women who had D&E with intact extraction had it because they had advanced cervical dilation or they had pre-term premature rupture of membrane syndrome, or PPROM, both of which are associated with high risk—high rates of uterine infections.

The women that underwent D&E with intact extraction were at significantly advanced degrees of gestation, that the median gestational age in this group was 23 weeks compared to a median gestational age of only 21 weeks in the women that had D&E with disarticulation.

Q. Is that difference in gestational age significant?

[1748]

A. It was highly statistically significant. The probability that this difference occurred purely as a matter of chance and didn't represent a true difference was less than one in a thousand.

Q. Why is it significant?

A. It is significant because, again, the literature that is out there is consistent with the notion that complications of D&E or any type of abortion, including medical abortion, increase with advancing gestational age.

So, in that the women that had D&E with intact extraction were at significantly more advanced gestational ages compared to those that had D&E with disarticulation, that these women would be expected to be at high risk of complication.

Q. So you would expect more complications at a later gestational age?

A. Absolutely.

Q. But you didn't find that?

A. We did not find that.

Q. Did the study keep track of the amount of blood loss for both intact D&E and the D&E with disarticulation groups?

A. It did.

Q. And what were the results regarding the amount of blood loss?

A. The results, the median blood loss of 100 milliliters was the same in both groups. The groups that had the highest [1749] rates, that the cases where there

were the highest degrees of blood loss were in the disarticulation group. But as a whole, looking at the distributions, they were not statistically significant between the two groups.

Q. Did you keep track of the procedure time for both intact D&E and the D&E with disarticulation groups?

A. We did.

Q. And what were the results regarding the procedure time comparing the two groups?

A. Similar to the blood loss. The median time of 22 minutes for using both variants was identical. The longest cases in the series—in this series were in the disarticulation group.

But, again, it wasn't a statistical—statistically significant difference in operating time between the two cohorts.

Q. You also indicated that the study looked at obstetric outcomes. Did the study find a difference in the obstetric outcomes of subsequent pregnancies between the two groups?

A. We did not.

Q. And what did the study find?

A. The study found in the 62—there were 62 patients who had subsequent pregnancies in our hospital, 45—and the proportions of the two variants were roughly the same as in the overall study.

Forty-five of these women had—with subsequent [1750] pregnancies had D&E with disarticulation, compared to 17 who had subsequent pregnancy who had D&E with intact extraction.

The variable we looked at was the rate of spontaneous pre-term birth. Two women in each of the groups had subsequent spontaneous pre-term birth. Two out of 45 was between four and five percent. Two out of 17 was between 11 and 12 percent. That difference did not approach statistical significance.

Q. What is the import of those results regarding obstetric outcomes?

A. Well, the other thing that we note in the "result" section of the study that is important to consider is that the two women out of the 17 that had D&E with intact extraction who had a spontaneous pre-term birth, both underwent abortion in the prior pregnancy because they had evidence of—that they would inevitably miscarry or deliver very prematurely.

One of these women had advance degrees of cervical dilation at around 23 weeks, and the other one had ruptured her membranes at 23 weeks, as well. So these two women, one delivered at 32 weeks in the next pregnancy, and one delivered at 35 weeks in the next pregnancy.

These two women, if they hadn't been touched, if they didn't have a D&E, or if they delivered spontaneously or medical induction or didn't have an intervention would be considered at very, very high risk for spontaneous pre-term [1751] birth in the next pregnancy.

And, indeed, these women had much, much, you know, much more successful obstetric outcomes in the prior pregnancy after undergoing D&E with intact extraction.

So to sum it all up, based on the data with subsequent obstetric outcomes, we do not see any

evidence that intact extraction increases the risk of spontaneous pre-term birth when that risk does not already exist.

Q. You indicated you looked at 62 women who had had subsequent pregnancies?

A. Yes.

Q. Is that number a sufficient number on which to base the conclusions that you've drawn?

A. I think it's a sufficient number to say that if there is any impact upon the D&E overall, or the specific variation of D&E, that the impact or the relative impact in terms of risk of spontaneous pre-term birth is likely to be small.

Q. What was the overall conclusion of your study as to the relative safety of the two variations of D&E?

A. The overall conclusion—and this being the first study that has looked at this topic, I think we were appropriately conservative in our conclusions. The overall conclusion is that these are both safe procedures, and that the complication rates in the subsequent pregnancy outcomes, with the caveats that I have described already, appear to be comparable. And [1752] that sort of the take-home message is that the appropriate way to perform a D&E at these gestational ages should be based on the intraoperative judgments of the physician.

Now, in the conclusion, you know, we also speculate that in the 120 women who had D&E with intact extraction that the—that it is very likely—that we think it is likely that the ability for us to use our judgment, to implement our judgment and to use this technique, or variation of D&E, likely avoided some of

the complications, and especially severe complications that were seen in the other cohort patients.

Q. Do you have an opinion as to what the study shows about the relative safety of the two variants?

A. Yes.

Q. What is that opinion?

A. Again, the opinion expressed in the paper—and is a valid opinion—is that they are both safe procedures. But I think in looking at the data, I conclude that D&E intact extraction could have safety advantages.

Q. Why is that?

A. Again, the two cohort patients were not the same. And to me, the most salient differences with were the gestational ages, the women having D&E with intact extraction were at more advanced gestational ages. And the higher proportion of them were undergoing D&E because they had ruptured membranes or significant degrees of cervical dilation, both of which are [1753] associated with complications.

Because the intact extraction cohort would be expected, very reasonably, to have higher rates of complications, and we, in fact, did not see that, and we saw fewer, although not statistically significant difference, but we didn't see any severe complications, that this suggests that the ability to use the intact extraction variation of D&E is safer and does—and when it is feasible does prevent complications.

Q. Do any other results from your study support your opinion that intact D&E may, in fact, be safer?

A. Yes.

Q. What are those results?

A. As we described, similar to the overall rate of complications, the intraoperative blood loss and the operating times, because with the advanced gestational ages that we saw in the intact extraction cohort, we would expect—and, you know, the medians were 21 and 23 weeks in the two groups.

The size of the fetus at 23 weeks, based on weight, is approximately 50 percent more than the size of a 21 week fetus. The size of the—the relative placental sizes also would probably correspond to that difference. That I would expect that removing the fetus and placenta at those gestational ages would take longer.

So, again, I think that the data are consistent [1754] with—if we didn't see any difference in operating—any significant difference in operating times in the two cohorts of patients, that that suggests that use of intact extraction can shorten operative times.

And, again, shorter operative times probably reflects shorter blood loss and less anesthesia exposure and would lower the complication risk and increase the safety.

And, again, looking at blood loss, again the same factors that we talked about. With increasing gestational age, the uterus is bigger. The amount of blood that the heart pumps to the uterus is more. Operative times may be more.

So, again, these are increased risks of hemorrhage. And to the extent that we didn't see any significant difference in the rates of blood loss, and we saw nonsignificant differences in the rate of transfusion, again, this suggests that the rate of blood loss—that

that use of the intact variation of D&E prevents or minimizes blood loss.

MS. PARKER: Your Honor, I am ready to move to the next topic, but I notice it is about 10:00.

THE COURT: Yes. I think it is time for our first break of the morning. We will break for 15 minutes.

(Recess taken at 10:00 a.m.)

(Proceedings resumed at 10:18 a.m.)

THE COURT: All right. Please continue.

[1755]

BY MS. PARKER:

Q. Dr. Chasen, we have been talking about two studies that you performed. I would now like to move to talking about your opinions based more on your clinical experience.

Do you have an opinion regarding the safety of intact D&E variant as compared to the disarticulation variant of D&E?

A. Yes, I do.

Q. What is that opinion?

A. My opinion is that in cases in which the intact extraction variant can be performed that this is a safer procedure than D&E with disarticulation.

Q. And why can intact D&E variant be the safest way to perform a D&E?

A. As I said before, my objective in performing any D&E is to remove the fetus and the placenta with a minimal amount of intervention. Every time I introduce a forcep into the uterus I run a risk of perforation. And every time I open the forcep and

grasp what I hope is fetal or placental tissue I could be grasping the uterine wall, and I could risk perforation.

My objective is to remove the fetus and placenta with as little of this type of manipulation as possible, and the intact variation of D&E allows me to do that.

Q. Have you ever perforated a uterus during a D&E procedure?

A. Yes, I have.

[1756]

Q Have you ever perforated a uterus or had a cervical laceration during an intact variation of the D&E procedure?

A. I have never had an uterine perforation with the intact variation of D&E. The few cervical lacerations I have had have been at the site of the tenaculum. It hasn't involved trauma to the cervix and removal of the fetus.

Q. In addition to the risks of laceration or perforation, are there other advantages to the intact variation of D&E?

A. Yes, I think so. In disarticulating the fetus and the dismemberment using the forceps, there can be sharp edges or boney fragments exposed that are not exposed in intact extraction. And in removing these from the uterus, that could risk trauma to the uterine wall or to the cervix.

And in the intact variation of D&E the boney fragments are not exposed at all to the maternal tissues. In that the procedure, based on my experience, can be accomplished more quickly when considering

gestational age, this would reduce the risk of infection and reduce the risk of blood loss, as well.

From wearing my hat, you know, as a maternal fetal medicine specialist and as a maternal fetal medicine specialist a lot of what I deal with are fetal abnormalities, which may involve genetic conditions, and these are a lot of my cases.

And a lot of my patients are terminating because of a fetal abnormality. And in some of these cases it may be due to a [1757] genetic cause. And there may be a significant risk of recurrence.

There are some D&E's I perform when we have a diagnosis, if I do an amniocentesis and the chromosomes are abnormal with Down's syndrome being most common, I have a diagnosis.

But there are other cases where usually based on ultrasound we can see clearly that there is something very abnormal about the fetus, and very often we can speculate upon the severity and really know that it is really a severe abnormality, but we don't have a diagnosis. And many different specific syndromes may have caused what we are seeing on ultrasound, but we don't know what.

In these cases the ability to do an autopsy for a trained pathologist, like I have at my hospital, to look at the fetal specimen and examine it can yield important information that could lead to a specific diagnosis, and that can lead to being able to do early prenatal diagnosis in a future pregnancy if a genetic test is identified. Or just in terms of counseling a patient about what the recurrence risk is.

And many patients, you know, what is most important to them is knowing why. These patients tend to be devastated.

They are devastated, all of them. And lot of it, what can contribute in no small measure is just not knowing what it is.

Q. So one of the advantages to an intact D&E is to have an [1758] intact fetus in order to do a pathology?

A. In a case where we can remove the fetus without having any disarticulation, then that increases the possibility—or decreases the possibility that any meaningful structure that may be abnormal may be damaged beyond recognition in doing disarticulation.

Q. Wouldn't that be an advantage to an induction, as well, the ability to get an intact fetus?

A. It could be. But there are a few other issues to consider.

In an induction, very commonly the fetus will not be delivered alive. In the course of an induction, it is not uncommon for the fetus to expire during the procedure. Induction—and the time between the death of the fetus and the time of the delivery can be many hours or it may be more than 24 hours. So by the time the fetus delivers, and intact, many of the structures that may be most relevant in achieving a diagnosis may have undergone a process called "maceration" where a type of degradation where important information may not be able to be obtained.

The other part about the induction is that we can never guarantee that the fetus will be able to be delivered by induction. And I think in most series suggest five to 10 percent of not being able to

successfully delivery the fetus with induction because of our ability, under many conditions, to not be able to duplicate the processes of labor [1759] pharmacologically.

So, a minority, but a real thing. It happens in a minority of occasions. But any woman having a medical induction may not deliver through medical induction, and she may need to subsequently have a D&E.

So, again, I can't guarantee any woman under either scenario that she'll deliver an intact fetus.

Q. In your opinion, does intact D&E offer safety advantages for women carrying fetuses with specific types of fetal anomalies?

A. Yes. Probably the most common scenario here is a condition called "hydrocephalus" in which there is typically obstruction in the flow of cerebral spinal fluid, or brain and spinal fluid, and that causes an accumulation of fluid in the brain.

And, typically, that—or very often that will result in the size the fetal head being disproportionately larger, oftentimes very much larger, than the gestational age that the fetus is.

And in these cases in doing a disarticulation, and in the process of disarticulation the fetal skull really needs to be grasped and crushed with forceps. And if the head is significantly larger than the gestational age would dictate, then the—I may need to open the forceps to a very wide degree. And the wider I open the forceps, the more likely I am to traumatize or perforate the uterus.

[1760]

In doing D&E using intact extraction, the fetus is delivered as a breech, and the head comes down to the same level of the cervix as in any other D&E with intact extraction.

And it lodges similarly in the cervix. And under direct visualization, I can make an incision with scissors and decompress the head the same way with the suction.

So there isn't the risk of—there isn't a risk of needing to open forceps to a wide enough degree to crush the fetal skull in those cases. There are other cases where certain anomalies, other portions of the fetal anatomy can be distorted and be enlarged. There is a condition known as "hydrops," which is not a specific diagnosis, but it is a condition very akin to heart failure, where fluid can accumulate to sometimes an enormous degree in certain cavities. And it can accumulate in the abdominal cavity. And the abdominal cavity can sometimes be very, very large.

And, again, the same problem will happen in trying to crush this part of the fetus with forceps could expose a woman to a greater degree of risk than in moving this part of the fetus through the breech extraction to a much lower part of the uterus.

Q. I have one follow-up question on hydrocephalus. Could you use a procedure called cephalocentesis to reduce the size of the head?

[1761]

A. Cephalocentesis can be used. And I published on this, and I have done it in a handful of cases in women closer to term to avoid having to do a c-section.

Q. So why don't you first describe what cephalocentesis is and then—

A. Cephalocentesis is a procedure in which a needle is placed through the fetal skull, and the fluid that has accumulated in a fetus with hydrocephalus can be removed. Sometimes liters of fluid can be removed. And the size of the head can be normal or closer to normal.

In the case of hydrocephalus in a woman undergoing a D&E, cephalocentesis is something that can be done. However, the condition—after it is done, the fluid can reaccumulate rapidly.

I have had one case I can recall in a woman in labor at term where I removed several liters of fluid. The head was reduced to a normal size. And then, by the time she was ready to deliver several hours later, the fluid had reaccumulated and the size of the head was as big as it had been before.

So doing a cephalocentesis prior to laminaria insertion or prior to being in the operating room would run the risk of needing to repeat this procedure.

And if I waited until the time of delivery of the cephalocentesis, the problem is that cephalocentesis is a destructive procedure. Most fetuses that have this procedure [1762] done during the process of labor or in the process of a D&E, it is a destructive procedure, and it results in a high rate of fetal death.

So, if I did a cephalocentesis—if I reduce the size of the fetal head by cephalocentesis while I am doing a D&E, rather than decrease the fetal head, as I have described before, I think that would violate the act.

Q. In your opinion, does the intact variation of D&E offer safety advantages for women with particular maternal health conditions?

A. Some of the cases I do because of deteriorating maternal health. And, again, the way I do a D&E with the dilation and how I choose a procedure doesn't differ between them. The way I dilate the cervix and the appropriate procedure I am choosing in the operating room doesn't differ at all.

But what is different in these women who are in a tenuous medical state is that these are the women least able to tolerate any complication, be it hemorrhage or uterine perforation or something else.

So to the extent that I believe that the ability to use intact extraction minimizes the risk of complications in all women, in these women who are least able to tolerate a complication would be most threatened by it. The ability to use intact extraction, based on my judgment is particularly—is a particular safety advantage in these women.

[1763]

Q. Let's talk specifically about patients who have a particular risk for blood loss or hemorrhage. Does the intact variation offer safety advantages for them?

A. As we discussed, I think it is my opinion—I think that the data in the studies is consistent with this—that in all women the ability to use intact extraction can decrease operative time and minimize blood loss.

Women that may be anemic, such as women with advanced—women on chemotherapy or women with other advanced stages of medical illness, these women are, again, most likely to be injured by hemorrhage.

And many of these women are technically prone to hemorrhage, because not only is their blood count low, but their concentration of clotting factors may be low, as well.

So these women are particularly prone to hemorrhage and particularly prone to suffer from hemorrhage. And, again, in that I believe that the ability to use intact extraction when doing a D&E, when in my judgment that I can do that, that would avoid—minimize the risk of these complications that could be particularly harmful to such a patient.

Q. Does the intact variation offer safety advantages for patients who need an abortion urgently to protect their health?

A. Yes, I think it does.

Q. What type of conditions would lead a woman to need to have an abortion more quickly than otherwise?

[1764]

A. Women with—the physiology of pregnancy or the physiologic changes of pregnancy are most likely to effect women who have heart disease. And oftentime these women tolerate the changes well until the second-trimester when the changes become most pronounced. And we can see marked deterioration so that we know if the pregnancy continues, that they would be at risk of death or other severe complications.

So we know that in a woman like this, or perhaps in a woman who—the rare woman who has severe preeclampsia develop in the second-trimester, and we know that if that woman is not delivered of the fetus in a relatively short amount of time, that this woman could die or sustain other dreaded complications.

It is not that the pregnancy needs to end in a matter of minutes or even in a matter of a few hours, but it is urgent enough that it really needs to be done within the next day or two.

And I think in these women I think D&E—and specifically using intact extraction—is a preferred choice, if possible.

Q. Would women with severe cardiac conditions, would induction be an option for them?

A. Induction might be an option. The problem with induction is that for a sustained amount of time the induction method, in that it causes, by nature, labor. And every time the uterus [1765] contracts that causes physiologic changes in the body. The uterus contracts and gets smaller. A lot of blood that's in the uterine circulation gets injected into the general circulation. And in women with deteriorating cardiac health, this exposes them to a prolonged period of jeopardy.

Contrast that to a D&E procedure. The cervix is not dilated through a process of labor. It is dilated with osmotic dilators that typically doesn't cause contractions. Doesn't change body wide changes in physiology. And I wouldn't expect that procedure of dilation to effect their cardiac status.

When the evacuation occurs, all the physiologic changes, when the uterus—when after the fetus and placenta are removed, then the uterus contracts down, and the physiologic changes happen, it happens in a very controlled setting. The patient is under anesthesia with an anesthesiologist who is very skilled in critical care right there. It is expected. It is anticipated.

Whereas, the delivery, the labor and the delivery in medical induction, we don't know how long it is going

to take, if it is going to be successful, whether it is going to take 12 hours, 24 hours or longer. And it exposes the patients to a prolonged duration of the these changes that they may not tolerate.

Q. Would a hysterotomy be an option for women with severe cardiac conditions?

[1766]

A. I think the only time when hysterotomy is indicated is in a woman who is in cardiac arrest, needs cardiopulmonary resuscitation or CPR, and you need to empty the uterus in a matter of minutes to save the maternal life.

Only in that circumstance, I think, is hysterotomy indicated. Hysterotomy, which is like doing a c-section, is the most invasive way—it is the most invasive thing you can do. It would be associated with the highest rate of complications, including infection, hemorrhage.

And, again, if a woman is having deteriorating medical condition and she needs to deliver, that would be the last thing that I would want to have to resort to.

And either induction or D&E would be preferable. And, again, for the reasons I have stated I think D&E is preferable to induction in these women.

Q. Are there other conditions where a woman might need to have an abortion more rapidly to protect her health?

You've talked about cardiac conditions.

A. Sure, there are. If a woman has an infection, and, again, some women they may have an infection. They may have had an amniocentesis a couple weeks ago, and

that could introduce bacteria into the uterus and cause an infection. They may be in pre-term labor, which can happen in the second-trimester, or they may have ruptured the membranes, both of which can be preceded by infection or both of which can lead to an infection [1767] in the uterus. These women are at risk of experiencing sepsis, which is a life-threatening condition with a body wide infection if the pregnancy is continued.

These women may need to be delivered urgently. And I think that D&E is the safest way to treat these women.

Q. Would you ever recommend an induction procedure for women who need an abortion immediately due to an emergent health condition?

A. The problem with an induction is that, again, in addition to the problems I have stated about the changes in physiology in women that may not be able to tolerate these changes is that an induction can take hours or it can take days where it may not be successful at all.

A D&E, I can replace laminaria at eight hours or 12 hours, so I can achieve the same degree of dilation that I would achieve at 48 hours in the normal case in a much compressed time interval. And I—it's a much more reliable time frame in which I can end the pregnancy that needs to be needed for a medical reason.

Q. And for those patients, would the entire D&E process occur in the hospital?

A. Yes, it would.

Q. And would you ever do a hysterotomy for women with any of those conditions?

A. Again, given that it is the most invasive thing that would [1768] lead to the highest rate of short-term complications, and also it would be most likely to effect their future pregnancies, no.

I would not, except, as I say in a woman that needs to be delivered that minute to do CPR or to resuscitate her.

Q. What procedure would you perform if a woman came to you at 20 weeks LMP who had had two previous vaginal deliveries, a bleeding placenta previa and clotting disorder?

A. In any woman with a placenta previa—that is a condition in which the placenta covers the cervix. In any woman with placenta previa, labor is contraindicated. That is a term that's medical induction if an abortion is done in the second-trimester.

So my choice is in such a woman would be hysterotomy. And I pretty much expressed how I feel with that, in general, or D&E. And in my experience I have taken care of women with placenta previa, in the circumstances you are describing. And in a hospital setting, I would insert laminaria. In my experience in the cases I have done it has not led to hemorrhage, and we have had enough time to achieve dilation of the cervix so that a D&E could be performed, and these women don't need a hysterotomy.

Q. What about a woman who came to you with three previous cesarean deliveries, evidence of placenta accreta and is presenting at 22 weeks LMP, what procedure would you recommend under that circumstance?

[1769]

MR. QUINLIVAN: Your Honor, I object to this question, and I move to strike the previous question. Neither of these situations were addressed either in Dr. Chasen's expert report or during his deposition.

THE COURT: All right. Those are the parameters.

MS. PARKER: What?

THE COURT: Those are the parameters, unless it is for impeachment or rebuttal or something of that with nature.

MS. PARKER: He is a rebuttal witness, your honor, and Dr. Cook expressly was given these two scenarios as hypotheticals. And he gave an opinion as to what procedure he would perform for these two scenarios. And we are presenting Dr. Chasen as a rebuttal expert on that.

THE COURT: Okay. I am going to permit it. He wasn't designated, obviously, except as a witness in your case-in-chief. I do think it is appropriate to use him now in rebuttal to Dr. Cook.

BY MS. PARKER:

Q. Do you need me to repeat the question or you have it firmly in your head?

A. I have it firmly in my head. And before I answer that question, I think, you know, I haven't mentioned it yet, but women with—who have had a prior c-section or any other procedure leaving a scar in the uterus are particularly at risk for uterine rupture if they undergo labor under any [1770] circumstance, at term or in the context of a medical abortion.

So, I consider that a relative contraindication to medical induction in any patient with a prior c-section, for instance.

Now, in the patient you just described who has had, I think, three prior c-sections?

Q. Yes.

A. Three prior c-sections and placenta accreta that was suspected based on ultrasound, I think. Placenta accreta is a condition that we can strongly suspect based on ultrasound findings in which the placenta is abnormally adherent to the wall of the uterus because it is sort of growing into the scar of the uterus.

In a woman like this, placenta accreta is associated with—in many cases these women ultimately have a hysterectomy or ultimately require a hysterectomy. However, in some cases the placenta, indeed, is abnormally adherent to the wall of the uterus. The placenta can be left in sight. It can be left there in a woman who may not be bleeding after removal of the fetus. And, you know, it's—we have had several cases in my hospital, and there are several cases published in medical literature that over a long period of time the placenta may either be absorbed by the body or it may detach and deliver days or weeks later.

In a patient like this, I think she is a candidate |1771| for a D&E. However, in the course of the D&E I would not want to disrupt the placenta, because, again, if I pull on the placenta and the placenta is abnormally adherent to the wall of the uterus, that could perforate the uterus.

So I would want to be able to do a D&E where I would want to be able to remove the fetus without disrupting the placenta. That is something I can do

with a lot of confidence using the intact extraction variation of D&E.

When I use forceps to disarticulate the fetus, in any given pass, I can also be disrupting the placenta. And, again, that would, in this patient in particular, would run a particular risk of uterine rupture.

Q. Now, you've indicated that in the majority of circumstances your preference is to do a D&E, and, if possible, an intact D&E. But do you discuss with your patients the option of induction?

A. I discuss with all of my patients options, unless they have a life-threatening condition, and, really, in my opinion they must end the pregnancy, I discuss the options of continuing the pregnancy, and what that would entail, as well as the option of medical induction, yes.

Q. And in your experience is induction a safe method of abortion?

A. For most women induction is a safe method of bortion.

Q. In your experience, which method of abortion is safer, [1772] induction or D&E?

A. In my experience, D&E is a safer method of abortion.

Q. Why is that?

A. The complication rates associated with D&E are lower than the complication rates associated with induction. And I believe nationwide data supports lower rates of mortality, which, to me, suggests also lower rates of complications.

I think there is less of a risk of bleeding and less of a risk of infection. Women undergoing induction need to be hospitalized compared to women having D&E where, in most cases, it is done as an outpatient procedure, although this gets into patient preference, as well.

And a significant proportion of patients undergoing induction will not expel the placenta, and then they need an evasive surgical procedure to remove that.

And in some cases they will not expel the fetus in part, or at all, and then they may need to have a D&E, which under these circumstances would be riskier than doing a D&E that doesn't precede a medical induction.

Q. Based on your experience which is the more common procedure throughout the second-trimester, induction or D&E?

A. D&E.

Q. And why do most women choose D&E over induction?

A. I think when it is available and women are presented with the two options, I think most women—not all—but most [1773] women express a preference for D&E compared to induction.

Q. And do you have an opinion as to why that is?

A. Yes. Again, induction is a procedure that is done in the hospital. With all my patients they feel like they have been struck by lightening. And, you know, they have had something devastating and unexpected happen.

And when they are informed that induction can take 12 hours or it can take 48 hours or it cannot be successful at all, that's something that is distressing to very many of them who are already distressed.

When they have to be hospitalized instead of being at home where they are more likely to have a support system intact, I think that is meaningful to a lot of women.

Women who—

MR. QUINLIVAN: Your Honor, I have to object. It seems to me that he is speculating as to what women may feel. He—if a woman has told him directly, that is one thing, but I object—

THE COURT: The objection is sustained. We have allowed this kind of testimony from other witnesses who are able to establish the foundation that they obtained this knowledge through in their own patient practice.

You haven't established such a foundation with him.

MS. PARKER: That is fine. I can do that, your Honor. And I think we are almost wrapping this line of [1774] questioning up, anyway.

BY MS. PARKER:

Q. All right. Dr. Chasen, you indicated that when patients come to you you discuss with them the various options; is that right?

A. Yes, it is.

Q. And do your patients—do you have a discussion with your patients about what options are available?

A. Yes, I do.

Q. And then, do you talk to them about which options they want to pursue?

A. Yes, I do. I describe what either option will entail, either of the three options, including continuing the pregnancy would entail.

Q. In the course of that do your patients describe to you their preferences for particular procedures?

A. They certainly do.

Q. And why they want a particular procedure over another one?

A. Yes, they do.

Q. And in the course of that, do they discuss with you why they prefer the D&E procedure over the induction procedure?

A. Often, in great detail and with great emphasis.

THE COURT: All right.

BY MS. PARKER:

Q. I don't know if you finished your testimony about why your [1775] patients preferred D&E's over induction.

A. I think—

THE COURT: I want to make sure your testimony is based upon your patients and not speculation as to other patients.

THE WITNESS: No. No, it is not speculative. This is what women tell me. This is what my patients have told me. That is how I know how they feel.

I talked about the more predictable nature of when a D&E will start and when it will be completed. I talked about women's preference for not being

hospitalized. Many of my patients—most of my patients are professional women. And they—in many cases, their colleagues may not even know they are pregnant, or they may not have disclosed that.

And they can go to work after they have had laminaria placed, and then they take, you know, only one or two days off. Rather than having to be hospitalized and to lose more time.

So, for variety of reasons I think they—my patients, in general, express a strong preference for an outpatient procedure rather than an inpatient procedure.

Another big issue is going through labor. That women—I am not a woman, but I am an obstetrician. And I think I—women regard, not inappropriately, labor as a very painful procedure.

[1776]

Women undergoing induction do get appropriate analgesic that usually consists of epidural anesthesia, but they are awake throughout the procedure. Epidural doesn't remove all painful sensations.

And most women express a preference for not wanting to be awake and aware of what is going on during delivery.

So I think these are all reasons why the patients that I see who know that D&E performed in a safe setting by an experienced practitioner like me or my colleagues who do this are far preferable than medical induction.

BY MS. PARKER:

Q. Do you have an opinion as to whether inducing labor between 20 and 23 weeks is a more physiological process than a D&E procedure?

A. Yes, I do have an opinion.

MR. QUINLIVAN: Your honor, I want to note my objection for the record. This, again, is an issue that was not raised in Dr. Chasen's expert report nor addressed in his deposition.

THE COURT: All right.

MS. PARKER: It is rebuttal.

THE COURT: To Dr. Cook?

MS. PARKER: Yes, your Honor.

THE COURT: It is unfortunate, obviously, that the plaintiff was unable to call the witness after because [1777] obviously you wouldn't have had this opportunity but for the scheduling difficulty to have a rebuttal witness. But he is here, and Dr. Cook did testify as to these specific things, so you are permitted to go beyond the deposition and expert report, but only to the extent that he is regarding specific testimony given by one of the defense witnesses.

MS. PARKER: This is specific testimony, as your Honor recalls, that was given by Dr. Cook.

THE COURT: All right.

THE WITNESS: Can you repeat the question?

BY MS. PARKER:

Q. Yes. What is your opinion as to whether inducing labor between 20 and 24 weeks is a more physiological process than the D&E procedure?

A. I don't agree with that.

Q. And why not?

A. First of all, our ability to mimic a natural physiologic process in inducing labor, or our inability to do that is one of the big, big public health issues that is confronting obstetrics, in general, today. Regarding our ability to do it in women at term, we are not that good at it, and that is one of the reasons that has contributed to rising cesarean section rates, an increased use of induction of labor and our inability to mimic a natural physiologic process that is in labor.

And women who are remote from term, who are, most [1778] likely, very remote from the onset of the natural physiologic labor process, induction of labor is even more challenging.

And the—and we—our techniques may have improved. Misoprostol is, I think, an improvement over old pharmacologic forms of inducing labor, but we are not able to mimic the natural physiologic changes of labor, the natural intensity of uterine contractions or anything similar to it.

So I do not think that this is a physiologic process at all that we induce with medical induction.

Q. Would a women experience the same level of physiological stress by undergoing 24 hours of dilation following laminaria insertion than she would by undergoing 24 hours of labor?

A. She would experience less physiologic changes or stress, certainly, with the laminaria insertion. Laminaria exert osmotic effect on the cervix in that local area of her body.

In general, it does not induce labor. Or if it does, in very rare cases. It typically doesn't cause

contractions in the uterus. And it does not cause systemic or body wide physiologic changes as happen when labor occurs naturally or when we make an attempt to make it occur unnaturally.

Q. A few more questions about the complications of induction. You indicated that, I think, retained placenta was a complication of induction?

A. Yes.

* * * * *

[1779]

Q. And how often does that occur?

A. I think based on our experience at my hospital, as well as published studies, I think it occurs ten to twenty percent of the time.

Q. Have you ever seen an induction fail?

A. Yes.

Q. And why could it fail?

A. Again, because of our inability, using the most current methods of pharmacologic intervention to initiate or to try to mimic a natural physiologic process. Some women don't respond to whatever formulation of prostaglandin or pitocin that we try to use.

In some of them we just can't induce labor. Not most of the time, but it can happen some of the time.

Q. How would you go about evacuating the uterus if the induction failed?

A. If the induction failed, then the best option would be D&E.

Q. And have you seen inductions where the fetus is partially delivered up to the calvarium and then becomes trapped?

A. Yes, I have.

Q. And what do you do under those circumstances?

A. Under those circumstances I think the least invasive and if—if the mother doesn't have—if she is not bleeding a lot, or she doesn't have any urgent need for immediate delivery, an option is to do nothing.

[1780]

Now, again, in an awake patient who can perceive this fetus in her vagina and portions of external to her, that is often not an acceptable alternative, doing nothing and waiting. Some women, the placenta may have detached. She may be bleeding heavily, so urgent intervention is necessary.

The options here could include something called Duhrssen's incisions, which are when the cervix is incised so that a trapped fetal head could delivery. That is a very invasive procedure that could cause hemorrhage or other complications.

And that is something that, I think, could damage the cervix and lead to cervical incompetence, not that I like that term, in the future.

Another very invasive thing, obviously, would be hysterotomy. I think the least worse alternative in that circumstance is to do what I would do in the course of an intact extraction while I am doing a D&E, to make an incision at the base of the skull and to suction out the brain tissue so that the head could pass through the cervix easily.

Q. Do you routinely use either KCl or digoxin to cause fetal demise before starting to evacuate the uterus in a D&E procedure?

A. I do not.

Q. Why not?

A. In the D&E procedure, it doesn't facilitate the procedure. [1781] It does not make it easier. A procedure like this, the patient is awake. It is, in most women, not associated with a great deal of pain, but in some women it may be.

The cases that are easy may only take a few minutes, but many cases aren't easy, and it could take a long time to do that.

In my hospital, we don't use digoxin. We use potassium chloride. And we inject that either directly into the umbilical cord or into the heart of the fetus.

And, again, in some cases for technical reasons this can be extremely difficult or impossible to do. Some women are very obese. Some women have an abnormal uterus that may have very large fibroids between—that make it difficult to navigate.

Some women may have be carrying a fetus with an abnormality associated with no amniotic fluid or she may have ruptured her membranes and have no amniotic fluid. And the lack of amniotic fluid can severely compromise our ability to see anything with ultrasound, because the ability to visualize things on ultrasound depends on a liquid/solid contrast so that the sound waves can penetrate.

So without that contrast with no amniotic fluid we oftentimes are very limited in our ability to an ultrasound-guided procedure.

Another reason is if there is a fetal abnormality [1782] for which evaluation by a pathologist can produce useful information, inducing fetal death in advance of D&E could, again, cause the process of maceration or degradation of fetal tissue to begin. And, again, that could cause a loss of information that could be useful otherwise.

Q. Have you ever cut the umbilical cord to cause fetal demise before evacuating the uterus in a D&E procedure?

A. Not with that intention, no.

Q. Do you generally cut the cord?

A. Not with that intention. I don't specifically do it as a specific step in the procedure to be done prior to anything else.

Q. And why not?

A. It doesn't facilitate the procedure. The cord may be not easily accessible in some cases. If I am doing a manipulation in the uterus, either with my hands or with forceps, with the only intent being to grasp the cord and cut it, I am not doing anything that is going to facilitate the procedure that I am there to do.

It could prolong the operative time, and it could increase the risk of complications. So I don't do that.

Q. Dr. Chasen, you are familiar with the Partial-Birth Abortion Ban Act, are you not?

A. Yes, I am.

THE COURT: Excuse me. Before you change subjects, [1783] I want to make sure I understood. You said at your institution you don't generally use digoxin, but you do on occasion use potassium chloride?

THE WITNESS: Yes.

THE COURT: Okay. All right.

BY MS. PARKER:

Q. So you are familiar with the Partial-Birth Abortion Ban Act of 2003?

A. Indeed I am.

Q. You are a plaintiff in the New York case; is that right?

A. Yes, it is.

Q. And you are currently covered by the injunction in that case?

A. Yes, I am.

Q. I have put up on the easel the operative portion of that act. Is it your opinion that the way you perform a D&E abortion would violate the act?

A. It may.

Q. Why is that?

A. When I do a D&E with intact extraction, then I think that could violate the act based on my interpretation of the sequence of the steps listed there.

When I am doing a D&E and I have made the decisionto proceed with disarticulation with forceps, the act doesn't say a thing about a fetus being delivered intact. It only [1784] describes one portion of the fetus being delivered before an overt act that I know will kill the partially delivered living fetus.

It is not my practice to document after every step in a D&E whether the fetus is alive or not, because, again, that doesn't facilitate any step of the case, and it could prolong it if I stop and consider that in every case.

And I can and I am sure I have in certain cases removed or delivered a portion of the fetus above the umbilicus outside the mother. And I have no doubt in some of these cases the fetus is still alive. And every time that I am introducing the forceps, my purpose is to remove the fetus. It's an overt act.

And I know that any time I introduce the forceps, I could do something. And, again, it is my intention to remove the fetus. And every time I perform such an overt act I know it could kill this fetus, portions of which I have removed already.

So I don't have any doubt, personally, that this act could cover any D&E that I do on a living fetus.

Q. Is it your opinion you would violate the act by the way you perform an induction abortion?

A. There are scenarios I can foresee in an induction abortion that could also violate the act.

MR. QUINLIVAN: Objection, your Honor. I don't [1785] think there has been any testimony that the witness does induction abortions.

THE COURT: I don't recall he has. You need to establish that.

MS. PARKER: I thought I had asked him that at the beginning of the—way at the beginning of the examination, but I will ask him that question.

BY MS. PARKER:

Q. Do you perform induction abortions?

A. Much less commonly than I do D&E, but, yes, that is something that I have done and can do.

Q. And is it your opinion that you would violate the act by the way that you would perform an induction abortion?

A. Again, I can foresee a scenario that could occur in which the induction abortion could violate the act.

Q. And what is that scenario?

A. Again, I could have a patient in the process of being induced could partially expel a fetus. For instance, the breech-presenting fetus could be expelled, partially, whereby the degree of cervical dilation could accommodate the fetus up to, but not including the head. The head could become entrapped in the cervix. A woman could be bleeding heavily, and I may need to do something quickly and emergently to complete the procedure in this patient that may be hemorrhaging.

[1786]

And what I could do to this fetus who may be alive could violate the act. That is true in a normal fetus. It may be especially true in a fetus with hydrocephalus, for instance.

Q. Do you manage spontaneous miscarriages as part of your practice?

A. I do.

Q Is it your opinion you would violate the act in the way you monitor spontaneous miscarriages?

A. I could.

Q. How could that happen?

A. Again, spontaneous miscarriage—again, some of the women that I do a D&E are in the stage of having a spontaneous miscarriage. They may be dilating the cervix. They may have ruptured their membranes. And

so a minority of patients on whom I do a D&E are in the process of having a spontaneous abortion.

Patients having a spontaneous abortion could present to me with the scenario that I just described with an induction. A patient in an advanced stage of labor in which the breech-presenting fetus is expelled, but the head is trapped within the cervix.

And, again, she may be bleeding heavily at that point. The delivery may be yet need to be accomplished quickly.

And under those scenarios I can do a hysterotomy, [1787] which I think is a terribly invasive and completely unindicated procedure in this circumstance to free the entrapped head.

I could do Duhrssen's incisions. And I feel that that is a very inappropriate thing to do.

And, again, in this case the most appropriate thing to do would be to make an incision at the base of the skull, decrease the size of the head, as I've described, and in this fetus that may be alive, that would violate the act, in my opinion.

Q. If the injunction were lifted, what impact would the act have on your practice?

A. It would have an impact, and not a good one. I would have to—in doing a D&E, I would have to consider every step that I am doing, not—when I am taking care of a patient, I think I want—and I especially think the patient and her family want me to have my full and undivided attention devoted to her, taking care of her.

If I am worried that anything I am doing in the process of doing a D&E could violate the act, then I may

do things differently. I may not be able to proceed as deliberately. I may prolong the case, because I am concerned about being prosecuted for taking care of my patient using my best medical judgment. And my patient could be harmed.

Q. And what impact would the act have on your patients?

A. My patients, they may not seek out a surgical abortion.

[1788]

Again, many with the passage of—

MR. QUINLIVAN: Objection, speculation, Your Honor.

THE COURT: Sustained.

BY MS. PARKER:

Q. Do you have an opinion as to what impact the act would have on your patients that is based on your own experience and counseling your patients?

A. Yes, I do.

Q. What is that?

A. I have many patients over the last year or two who are aware of attempts to limit my use of my medical judgment, or any obstetrician's medical judgment, in banning certain types of procedures to abortion. And more than a few patients have asked me if I am going to be doing a partial-birth abortion, or they may use the term "intact D&E." If I can do it, and specifically after this bill was enacted, they have expressed concerned about whether I can still take care of them or about whether they would be forced to

endure an induction that the thought of which they dreaded.

So if I were not covered by a restraining order or if this act were in effect, my patients might be under the false impression that they would have to have an induction. They may feel that they had to have an additional procedure, potassium chloride injection.

MR. QUINLIVAN: Objection, your Honor. He is now * * *.

* * * * *

[CHASEN—CROSS EXAMINATION]

[1794]

Q. And the reason you were only able to follow-up with pregnancy outcomes of 81 of those women is because some of the other women may have gone to their referring obstetricians; isn't that right?

A. Other women undoubtedly did go to their referring obstetricians.

Q. And in doing that study, you didn't follow up with women who went to, say, back to their referring obstetricians or to other obstetricians?

A. We did not.

Q. And you would agree, doctor, would you not, that the quality of your conclusion in that study may depend on the number of patients that you are able to follow-up at your institution?

A. It may.

Q. And you would agree, also, doctor, that the patients who underwent a D&E procedure at your

hospital and delivered elsewhere may have had a higher or lower rate of spontaneous birth?

A. As we acknowledge in the paper.

Q. And your answer is: yes?

A. Yes.

Q. Okay. Now, let's turn to your more recent study, which I believe is Plaintiffs' Exhibit 19.

Is it fair to say that the objective of your study [1795] was to compare the relative safety of two techniques for surgical abortion late in the second-trimester?

A. Yes.

Q. And, in fact, that is what you said on the first page of your study in the objective section; isn't that right?

A. That's correct.

Q. And the two techniques that were being compared as defined in the study were dilation and evacuation and intact dilation and extraction?

A. Those were the two variations of dilation and evacuation that we were comparing.

Q. Let me talk—let's talk a little bit about the description or the—or how you described the intact dilation and extraction or intact D&X.

A. Yes.

Q. In reviewing the medical records, you determined that if the fetus was delivered intact in the breech presentation to the level of the umbilicus or higher, the procedure was considered an intact dilation and extraction; is that right?

A. That is correct.

Q. And just to be clear, in laymen's terms the umbilicus is where the umbilical cord attaches to the fetus, right?

A. The best laymen's term is the belly button, yes.

Q. I was just about to ask for those of us, after the belly button is cut or after the umbilical cord is cut, that is your [1796] navel or belly button, right?

A. Yes.

Q. And if the fetus was delivered intact in the breech presentation to the level of the umbilicus or higher, you considered that to be an intact dilation and extraction, whether or not the entire fetus was removed intact or decompression of the head was required, right?

A. That is correct.

Q. And you selected breech presentation to the level of the umbilicus or higher, because the umbilicus is an easily identified landmark that you could identify, right?

A. That is correct.

Q. Now, there was another situation which might fall in the intact D&X category, and that was where the fetus was in the vertex or headfirst presentation, right?

A. Correct.

Q. And if the fetus was presenting headfirst, and the fetus' head was decompressed with suction, followed by an intact delivery of the fetus, that, for purposes of your study, constituted an intact D&X?

A. That is correct.

Q. Now, doctor, your study does not include all patients who had surgical abortions at Cornell during the period under your review; isn't that right?

A. That is correct.

* * * * *

[1809] of your study.

A. Yes.

Q. In the right-hand column, the second to last paragraph. The last sentence of the second to last paragraph you stated:

> "Because our approach is to perform intact D&X when possible on the basis of cervical dilation and fetal position, it is unlikely that intact D&X could have been performed in these patients undergoing dilation and evacuation who experienced severe complications."

Those were your records, right, doctor?

A. Yes.

Q. And I think—is it a fair statement to say that you perform an intact D&X whenever you're able to, so the fact that a D&E procedure was performed in those patients suggests that you couldn't perform an intact D&X in those three cases?

A. As I will readily acknowledge.

Q. Now, doctor, you also testified on direct examination that you believe your study supports the comparative safety of the intact D&X procedure because of the higher gestational age in the intact D&X group as compared to the D&E group?

A. Yes.

Q. But you don't make any such claim in your article, do you?

A. In the discussion we make reference to that.

Q. But you don't claim in that discussion that the intact D&X [1810] procedure is safer because of the higher comparative gestational age. That is not one of the conclusions of your paper, is it?

A. No. Our conclusions were conservative.

Q. In fact, because this is a retrospective study, the data will not support a statement that one technique is safer or superior to the other, correct?

A. That's correct.

Q. And you said as much in your article; isn't that right, Doctor?

A. Yes.

Q. And turning back, again, your attention to page 4 in the left-hand-column, in the middle of the page, the last sentence of the paragraph beginning "our approach," it states:

> "Though we believe our low complication rate validates our approach, we knowledge that the retrospective nature of this study precludes us from concluding with certainty that intact D&X prevented adverse outcomes."

Those were your words, right, Doctor?

A. Those are the words.

Q. Now, doctor, am I correct that you could have stratified the gestational ages? You could have compared intact D&X procedures as compared to D&E

procedures at different gestational ages? Say at 21 weeks, 22 weeks and 23 weeks?

* * * * *

[1820] intact D&X procedure is rarely used in cases of maternal medical condition?

A. Preoperative indication that maternal medical conditions are a small minority of the cases that we do.

Q. You would also agree, Doctor, that if a woman was experiencing a severe medical condition or had a fetal anomaly that would impact your choice of either performing an intact D&X or D&E procedure; is that right?

A. That's right. It would be based on my intraoperative judgment about what would be safest.

Q. And, in fact, you don't take steps in any cases involving maternal health conditions or fetal anomalies to ensure that you were going to end up with an intact D&X procedure, do you?

A. No, because I can't ensure that.

Q. Now, you also testified that in some cases of fetal anomalies you think the intact D&X procedure offers some advantages in terms of pathology?

A. Yes.

Q. But a labor induction, you acknowledge, would also offer an intact specimen for purposes of pathological assessment, correct?

A. In most cases it would.

Q. Am I correct, doctor, that there are some fetal anomalies where it is important to examine the content of the brain matter?

* * * * *

[1822] you could do the cephalocentesis process again; isn't that right?

A. It could, and I have.

Q Doctor, am I correct that in your opinion an intact D&X procedure is never the only available procedure to terminate a second-trimester pregnancy?

A. That is correct.

MR. QUINLIVAN: Moving on to my last subject, your Honor.

BY MR. QUINLIVAN:

Q. Let's talk about injections for a little bit. You testified you don't normally use an injection of potassium chloride or digoxin, right?

A. In most cases I do not.

Q. But you do offer injections of potassium chloride if the woman requests it, correct?

A. That's correct.

Q. Your institution has a policy of offering injections of potassium chloride after 24 weeks; isn't that right?

A. We don't do abortions on fetuses after 24 weeks.

Q. Well, doctor, I believe that one of the cases in your study was a fetus at 26 weeks and 27 weeks gestational age?

A. Spontaneous fetal demise.

Q. After 23 weeks gestational age you offer the woman the option of having an injection by potassium chloride; is that * * *.

[1825]

[STEPHEN T. CHASEN, M.D.—REDIRECT EXAMINATION]

BY MS. PARKER:

Q. Dr. Chasen, Mr. Quinlivan asked you about the study that is going to be published this spring. Did your participation in the New York litigation introduce bias into that study in any way?

A. No.

Q. And why is that?

A. My purpose in participating as a plaintiff was to ensure that I could take care of my patients consistent with my medical judgment in the best way I can to take—provide the best care I could.

My objective in doing the study, as in any study, is to answer a question or attempt to contribute—or nothing resolves certain controversies—but to contribute to the literature in a way that could give relevant or meaningful information regarding anything that isn't resolved, and few things in medicine are resolved.

It gives me no pleasure in doing D&E, whatever technique I do. And there is—you know, the only reason why I want to be able to use my judgment and perform a D&E with intact extraction when I can is because based on my experience and expertise, that is the best way I can take care of my patients.

I did the study because there is no published data.

[1826]

Now, based on my opinion and experience prior to doing the study, I didn't perceive the risks that have been asserted in the absence of any data regarding this procedure.

But, if those risks did exist, or there were circumstances where this variation of D&E were to appear risky to some women, or to be disadvantageous relative to D&E with disarticulation, that would be very meaningful information to me, and perhaps to my colleagues in the profession, who do these procedures in terms of how we can best take care of our patients.

My capacity as a researcher and an author, my capacity as a physician who takes care of patients, and my capacity as a plaintiff in any judicial proceedings are not in any way conflicted with each other.

And, again, I don't take any pleasure from doing intact extraction compared to disarticulation. I do take satisfaction in providing the best care I can to my patients and helping them in what is very difficult time in their lives and trying not to make it any harder.

Q. Are any of the other authors of that study plaintiffs in the New York litigation?

A. No, they are not.

Q. Mr. Quinlivan also asked you some questions about your expertise with induction abortions.

A. Yes.

[1827]

Q. Is that a procedure that you teach in your teaching capacities?

A. Yes, it is.

Q. And do you have expertise in performing induction abortions?

A. I do. What I stated was I don't have special expertise compared to my colleagues. And there are many more obstetricians in my department who have expertise in induction who don't do D&E's. I do have special expertise in D&E. I have equivalent expertise to many physicians in performing inductions. So—but that is that.

Q. And why don't you perform induction abortions more regularly?

A. Again, in my capacity as a maternal fetal medicine specialist and my teaching, administrative and research capacities, I don't have a whole lot of time to do a lot of abortion procedures. That doesn't constitute the main aspect of my clinical care. It is a small minority of it.

And, again, I do those cases for which I have special expertise. And D&E certainly qualifies as that. And given I don't have an obstetric practice, I don't have my own private prenatal patients. And women who want to have an induction, in general, they are cared for by their obstetricians and they are not referred to me for an induction.

That's why almost all the cases I do are D&E and not [1828] inductions. It's not because I lack any requisite expertise in induction.

Q. On cross you testified in response, again, to some questions about the safety study that the data don't support a conclusion that intact D&E prevented adverse outcomes given the retrospective nature of the study; is that right?

A. I think I said "we can't conclude with certainty."

Q. But do you have a medical opinion about that?

A. I do.

Q. And what is the medical opinion?

A. My medical opinion is that these 120 cases that were able to be completed with intact extraction at a median gestational age at 23 weeks that, number one, I think it is very impressive that no major complications was seen in any of these women.

And that if I or my colleague in doing these procedures did not have the ability to implement our best medical judgment, and specifically were precluded from performing intact extraction, that I really don't have much doubt, having done these procedures, that some of these 120 patients, not most, but some, would have experienced major complications.

Q. And you also were asked some questions about, I believe, 62 patients who had subsequent pregnancies in the second study that you conducted. Given the limited number of those for whom you could assess the subsequent pregnancy outcomes after D&E's, [1829] why did you include the data in your study?

A. I included the data—and, again, I think this was contained in a letter to the responding—to the peer review, there isn't any data out there. Some data is always better than no data.

Would it have been better if we had triple or quadruple number of patients? Sure. But given the large lacuna in the medical knowledge regarding this specific—

THE COURT: What was that word, doctor?

THE WITNESS: "Lacuna." It means a gap. Sorry.

That given that I think it is valuable data, and I think —and it was acceptable to the editors of this journal who did not think it should be removed.

And, again, I think I would emphasize that none of the patients who wouldn't have been considered high risk based on their obstetric history that didn't even experience spontaneous pre-term birth in the next pregnancy who had intact extraction.

BY MS. PARKER:

Q. And there were also some questions about the two women who had intact D&E's and subsequently had pre-term birth?

A. Yes.

Q. Do you recall that? And in your clinical judgment, what is the most likely reason that they had pre-term births?

A. Well, honestly, there is a nobel prize for whoever can [1830] unravel the mystery of pre-term birth. So I don't know. But what I do know is that when you are assessing risk for pre-term birth, the strongest risk factor you can have is a history of a prior pre-term birth or a prior second-trimester pregnancy loss.

So, any maternal fetal medicine specialist should look at this and conclude that, again, without even touching these patients or regardless of how their pregnancies ended with whatever procedure, or naturally, that these women would be considered very high risk to deliver in the future.

And that I have no doubt that these—and that related to what happened or compared to what happened in the pregnancies that were ended with D&E, that they had markedly improved pregnancy outcomes in their next pregnancy.

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C 03-4872 PJH

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. AND PLANNED PARENTHOOD GOLDEN GATE, PLAINTIFFS

v.

JOHN ASHCROFT, ATTORNEY GENERAL OF THE UNITED STATES, IN HIS OFFICIAL CAPACITY, DEFENDANT

TRANSCRIPT OF TRIAL PROCEEDINGS

Apr. 8, 2004
Volume 6

BEFORE THE HONORABLE
PHYLLIS J. HAMILTON, JUDGE

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* * * * *

[WATSON BOWES, JR., M.D.—DIRECT EXAMINATION]

[873]

THE WITNESS: B-O-W-E-S.

THE CLERK: Thank you.

BY MR. QUINLIVAN:

Q. Good morning, Dr. Bowes. Welcome.

A. Thank you. Good morning.

Q. Dr. Bowes, are you affiliated with any academic institutions?

A. Yes, I am. I am emeritus professor of obstetrics and gynecology at the University of North Carolina in Chapel Hill.

Q. Can you tell us what that means to be an emeritus professor?

A. It essentially means I have retired from my clinical practice, although I still have some other responsibilities on the faculty.

Q. Doctor, are you licensed to practice medicine?

A. I am.

Q. In what state or states?

A. I am licensed to practice in North Carolina. I was previously licensed to practice in Colorado, as well, but that license is now inactive.

Q. Doctor, are you board certified in any fields?

A. Yes, I am board certified in obstetrics and gynecology and also in the subspecialty of maternal fetal medicine.

Q. Can you briefly explain what the subspecialty of maternal [874] fetal medicine is?

A. The subspecialty of maternal fetal medicine is—deals largely with problems of fetal diagnosis, fetal therapy, in other aspects as high risk pregnancies.

MR. QUINLIVAN: Your honor, may I approach the witness?

THE COURT: Yes.

BY MR. QUINLIVAN:

Q. Doctor, I am showing you what has been marked as defendant's exhibit A-2, and I would like you to identify that, please.

A. This is my curriculum vitae.

Q. Did you prepare it?

A. Yes, I did.

Q. Is it current?

A. Yes, it is.

Q. Is there anything in your curriculum vitae that is inaccurate?

A. Not to my knowledge.

MR. QUINLIVAN: Your Honor, at this time I move the admission of defendant's exhibit A-2.

THE COURT: Any objection?

MS. KRASNOFF: No objection, your honor.

THE COURT: Admitted.

THE CLERK: A-2 into evidence.

[875]

(Defendant's Exhibit A-2 was received in evidence.)

BY MR. QUINLIVAN:

Q. Doctor, I would like to ask you some questions about your professional background. When did you receive your medical degree?

A. 1959.

Q. And following medical school, can you briefly summarize your post-graduate education?

A. Following my graduation from medical school, I had an internship at the Mary Hitchcock Hospital in

Hanover, New Hampshire, which is affiliated with Dartmouth's medical school.

Then, I had a one-year residency in general practice at the University of Colorado medical center in Denver. This was followed by a one-year fellowship in fetal physiology at the same institution.

Thereafter, I spent three years as a resident in Obstetrics and Gynecology at the University of Colorado Medical Center in Denver. And that completed my formal training.

Q. Following your post-graduate education, did you have occasion to practice in the field of obstetrics and gynecology?

A. Yes, I did. From 1965 until 1967 I was in a private practice of obstetrics and gynecology in Denver, Colorado, and at the same time was a part-time faculty member at the University of Colorado Medical Center.

[876]

Q. What were your responsibilities as a part-time faculty member at the University of Colorado?

A. I was a member of the Department of Obstetrics and Gynecology, and my primary responsibilities were in the teaching of medical students, and developing medical student curriculum for obstetrics and gynecology and teaching residents that were in Obstetrics and Gynecology.

Q. Doctor, following private practice, you then joined the military?

A. Well, yes. I was invited to participate in 1967. I spent two years in the U.S. Army Medical Corps during

those two years, and was stationed at Madigan General Hospital in Tacoma, Washington.

Q. What were your responsibilities at Madigan General Hospital in Tacoma, Washington?

A. For most of the time I was assigned to the ob/gyn service. At that time it was a large teaching service with residents, and my responsibilities were to supervise and teach residents at that service.

Another portion of the time I was actually assigned to services as a general medical officer.

Q. Doctor, what was your rank during your tenure or your time in the U.S. Medical Corps?

A. When I entered the medical corps, I was a captain. And when I left the Medical Corps I was a major.

[877]

Q. Were you honorably discharged?

A. Yes, I was.

Q. Doctor, following your military service, did you then continue your career in academia?

A. Yes, I returned to Denver, Colorado, where I was a full-time—appointed to the full-time faculty at the University of Colorado Medical Center in the Department of Obstetrics and Gynecology.

Q. And what positions or academic titles did you have while at the University of Colorado?

A. I was initially an assistant professor and was promoted over the years there to associate professor, and finally to a full professor in the department.

Q. And can you give us a brief description of your responsibilities while a faculty member at the University of Colorado?

A. My responsibilities included three areas. One was the teaching and supervision of medical students, residents and fellows in obstetrics and gynecology.

I was also involved in doing research, supervising research, helping residents and fellows develop research protocols and so forth.

And I was also a member of the group practice of faculty members at the University of Colorado which we offered or provided care for patients in that practice.

[878]

Q. Doctor, you mentioned your research responsibilities or activities. Did you focus on any particular area of research while at the University of Colorado?

A. My major area of research at the University of Colorado was the treatment of a disease called erythroblastosis. That's the RH factor and its effect on fetuses, RH incompatability between mothers and babies. And we developed the fetal transfusion techniques for that disease.

Q. Doctor, did you have occasion to leave the University of Colorado at some point?

A. In 1982, I joined the faculty at the University of North Carolina where I have been since that time.

Q. And what positions or titles did you hold while at the University of North Carolina?

A. Well, throughout my time on the active faculty there, I was a full professor.

Q. And can you briefly describe your responsibilities as a member of the faculty at the University of North Carolina?

A. Well, my responsibilities at the University of North Carolina were quite similar to those at the University of Colorado. I supervised obstetrical and gynecological residents. I helped in the education of the medical students.

I was active in developing research protocols and performing research, clinical research. And I also participated in the group practice among the faculty members [879] that provided care to patients.

Q. Doctor, similar to my question about your research interests at the University of Colorado, did you focus on any particular area of research while at the University of North Carolina?

A. We were—I participated in the fetal therapy that was going on at the time, including the treatment of RH disease and other fetal conditions and also was involved in other research on high-risk pregnancies. These are pregnancies which involve medical diseases during pregnancies, diabetes and so forth.

Q. Doctor, did you serve is a member of any review committees while at the University of North Carolina?

A. Yes. In 1984, the medical school established the infant [illegible] was actually the hospital connected with the medical school—established an infant care review committee. And I was chairman of that committee from 1984 until approximately 1995, when that committee was absorbed into a larger ethics committee of the hospital.

Q. And what was the infant care review committee?

A. The infant care review committee had the responsibility of reviewing all cases in which medical care was either withheld or withdrawn from a critically-ill infant.

Q. And what were your responsibilities as chairman of that committee?

A. We supervised—I supervised and led the discussions at [880] the meetings in which these cases were presented, inviting the interested parties who could contribute to the conversation and oversaw the deliberations of the committee in making some decisions about those cases.

Q. Doctor, you mentioned you are now retired?

A. Yes.

Q. Do you currently see patients?

A. I do not see patients clinically, no, I do not.

Q. And when was the last time that you clinically saw patients?

A. 1999.

Q. Do you still maintain an active association with the University of North Carolina?

A. Yes, I have. I am a member and have been a member of what is called the Institutional Review Board. And that is the committee that oversees or reviews research protocols that are submitted for approval before those research studies are conducted.

Q. And how long have you been a member of the Institutional Review Board?

A. Little over five years.

Q. And outside of the Institutional Review Board, do you have any other duties or responsibilities as an emeritus professor?

A. I participate in teaching conferences and have small seminars with the OB/GYN residents from time to time.

[881]

Q. Doctor, over the course of your professional career, have you had occasion to become familiar with the medical techniques to perform abortions?

A. Yes I have.

Q. Can you describe for the court how you have become familiar with those procedures?

A. I have been—during my residency education, we were taught procedures that were involved in completing what were called "incomplete spontaneous abortions" or missed abortions. This is where the fetus dies early in pregnancy. Also we had pregnancy terminations for fetal deaths. And also during that time there were induced abortions for medical complications, medical or psychiatric complications in pregnancy.

Q. Can you tell us what particular techniques of abortion you were taught?

A. I was taught at that time three techniques: the technique of dilatation curettage for early abortions, later the suction curettage was introduced as a technique that was used. And for second-trimester abortions at that time we were doing labor induction-type of abortions.

Q. And have you subsequent or subsequent to your residency did you become familiar with other methods of abortion?

A. Yes, later—and this was when I was at the University of North Carolina—the D&E procedure had been developed as an alternative to the labor induction abortions in the [882] second-trimester.

Q. Can you tell us what a "D&E" means?

A. D&E, it's—those terms mean dilatation and evacuation. Dilatation of the cervix, dilating the cervix of the uterus and then evacuating the contents of the uterus with either instruments or suction devices.

Q. Doctor, can you estimate how many abortion procedures you have performed during your career?

A. Well, if we can separate those into those procedures we were completing pregnancies which a fetal death or early spontaneous death of a fetus had occurred, in the second-trimester probably 150 of those procedures. Of procedures which were done earlier in pregnancy, many more than that, because that is a much more common complication, so I can't give you an exact figure.

For induced abortions, abortions in which abortion was performed with a living fetus, far fewer. Maybe five to 10. I don't know the exact number, but it is a small number during my time at the University of North Carolina in which the procedures were performed. And probably 10 or 15 at the University of Colorado.

Q. Doctor, you mentioned only a small number of induced abortions. Do you have a philosophical or

ethical position regarding the circumstances in which you will perform abortions?

[883]

A. Yes, I do.

Q. Can you tell us what that is?

A. I believe that induced abortions are indicated only when there are medical complications that are a serious threat to the mother's life.

Q. Now, doctor, have you had occasions in your practice in which one of your patients chose to terminate her pregnancy for a condition other than one which would put her life at risk?

A. Yes.

Q. What would you do in those circumstances?

A. In those circumstances I've always recommended the patient see one of my colleagues who has different feelings about abortion than I do.

Almost all my patients are well-aware of my feelings about this. But I recommend that they get care from one of my other colleagues.

Q. Doctor, have you ever addressed the ethical obligations of a pro-life obstetrician and gynecologist in any published work?

A. Yes, a number of years ago or several years ago, two of my colleagues and I wrote an article that was published in the New England Journal of Medicine that was in response to an article that had appeared suggesting that a doctor who would not do abortions should not be a maternal fetal medicine specialist. And we were simply responding to that assertion.

Q. Doctor, are you a member of any professional associations?

[884]

A. I am a member of the American College of Obstetricians and Gynecologists and the Society for Maternal Fetal Medicine.

Q. Is the American College of Obstetricians and Gynecologists oftentimes referred by the acronym ACOG?

A. Yes, it is.

Q. Have you severed in any special capacity with ACOG?

A. Yes. For five years I was a member of the ACOG's committee on ethics. And for three of those years I chaired that committee.

Q. And what were your responsibilities as chairman of that committee?

A. My responsibility was to organize and lead the discussions of that committee that dealt with various ethical issues in obstetrics and gynecology, and prepare written reports that would then be disseminated to the fellowship or the membership of ACOG on those various topics.

Q. Doctor, are you—

THE COURT: Excuse me.

MR. QUINLIVAN: Yes.

THE COURT: I just want to clarify something the doctor said. You indicated that of the five to 10 induced abortions that you have performed, that those

were indicated because of medical problems or conditions of the mothers, correct?

[885]

THE WITNESS: Yes, ma'am. These are the ones at the University of North Carolina.

THE COURT: Okay. And of the 150 or so other procedures, I am assuming we are referring to D&E's; is that correct?

THE WITNESS: No, ma'am. Some would be D&E's. But some were also procedures done by the labor induction methods. And those were procedures I was referring to in which the fetus had died. These were done to complete a pregnancy when a fetal death occurred.

THE COURT: All 150 of those?

THE WITNESS: Yes.

THE COURT: Okay. All right. Thank you.

BY MR. QUINLIVAN:

Q. Doctor, just to clarify one point, you had mentioned five to 10 occasions in which you performed an abortion in which the life of the mother was at risk. Do you recall the specific number?

A. I don't recall the exact number. I don't have documents, but my recollection is that I think two or three were D&E's in which I was the supervising physician with the resident. The resident and I performed the procedure.

And the others were induction procedures.

Q. Doctor, are you currently involved in any scholarly activities in the field of obstetrics and gynecology?

[886]

A. Yes. My primary scholarly activity is the serving as the co-Editor-in-Chief of the journal entitled Obstetrical and Gynecological survey.

Q. And how long have you served as co-Editor-in-Chief of that journal?

A. I served in that capacity since 1992, so for 12 years.

Q. Can you tell us what Obstetrical and Gynecological survey is?

A. It is a journal now about over 50 years old that publishes abstracts from the wider medical literature on topics related to obstetrics and gynecology. These abstracts are each followed by a commentary written by one of the four co-editors.

And the journal also publishes review articles, two or three each month, on topics related to subjects in obstetrics and gynecology.

Q. Can you tell us what your responsibilities as a co-Editor-in-Chief of that journal are?

A. My responsibilities are threefold: one is to review the medical literature and select the abstracts that we publish; second, to write the commentaries about those articles; and, third, to review manuscripts that are sent to the journal to be considered for publication and to assess those articles and select those that we will publish.

Q. How often is Obstetrical and Gynecological survey published?

[887]

A. Monthly.

Q. And can you approximate how many journals you review a month in your service as co-Editor-in-Chief?

A. We review approximately 100 journals over a period of time to select the articles that we will abstract for the journal.

MR. QUINLIVAN: Your Honor, may I approach the witness?

BY MR. QUINLIVAN:

Q. Doctor, I am handing you what has been marked as defendant's exhibit 56. Are you familiar with that document?

A. Yes, I am.

Q. And without commenting on the substance, can you just tell us what that document is?

A. This is an article that—a review article that we published in the Obstetrical and Gynecological Survey.

Q. And is that an example of the kinds of review articles that you have been discussing?

A. Yes, it is.

Q. Doctor, are you a peer reviewer for any other journals?

A. Yes, I am.

Q. And what journals would those be?

A. I review articles primarily for two journals: Obstetrics and Gynecology. This is the official journal of the American College of Obstetricians and Gynecologists, and also for the American Journal of Obstetrics and Gynecology.

[888]

Q. How long have you been a peer reviewer for those journals?

A. At least 10 years.

Q. Are you a peer reviewer for any other journals?

A. From time to time articles are sent to me from other journals for review, such as the Journal of Maternal Fetal Medicine, Journal of Pediatrics and others.

Q. Doctor, have you yourself published scholarly articles in the field of obstetrics and gynecology?

A. Yes, I have.

Q. Can you tell us how many?

A. I believe my curriculum vitae lists 140 articles.

Q. And how many of those were published in peer review journals?

A. One hundred of those are in peer reviewed journals.

Q. Doctor, are you familiar with the medical literature regarding abortion?

A. Yes, I am.

Q. How are you familiar with that literature?

A. Well, I am familiar with it in two or three capacities. I review the medical literature monthly to

select articles as I have described for our journal. And in doing so you come across a number of articles about abortion, which I scan read to see if there is interesting information in there, although I am not primarily the person on our editorial group that selects articles in that area.

[889]

I also read our current journals, two journals I mentioned for which I review. I both receive those monthly, and they include a number of articles about abortion.

From time to time I have been asked to comment on or testify about abortion, like I am here today. So I review articles about abortion when I do that. And I have done that in the past.

And I have also read the textbooks which are pertinent to the subject, such as textbook by Dr.—that is edited by Dr. Maureen Paul and David Grimes and their associates, and the textbook by Dr. Warren Hunter.

So that's, in general, how I have been familiar with the literature.

MR. QUINLIVAN: Your Honor, may I approach the witness?

THE COURT: Yes.

BY MR. QUINLIVAN:

Q. Doctor, I am handing you what has been marked as Plaintiff's exhibit 31. Is that the Paul Textbook to which you are referring?

A. Yes, it is.

Q. Do you own a copy of that textbook?

A. Yes, I do.

Q. Doctor, does the journal for which you serve as co-Editor-in-Chief publish articles on abortion?

[890]

A. Yes, it does.

MR. QUINLIVAN: Your honor, at this time I would move to qualify Dr. Bowes as an expert in the fields of obstetrics and gynecology, in the field of maternal fetal medicine and the medical literature regarding obstetrics and gynecology.

THE COURT: Any objection?

MS. KRASNOFF: No, Your Honor, as long as it's clear he's not being qualified as an expert in abortion practice.

THE COURT: I believe—

MR. QUINLIVAN: I did not move for that.

THE COURT: He will be accepted as an expert.

MR. QUINLIVAN: Thank you, your honor.

BY MR. QUINLIVAN:

Q. Doctor, are you familiar with the term "evidence-based medicine"?

A. Yes.

Q. Can you tell us or describe for us what that terms means?

A. "Evidence-based medicine" is the term that is applied to the concept of developing data and studies that support various practices of medicine and to ensure that new innovations in medicine, or even older

practices, are supported by sufficient data to confirm their efficacy and their safety.

Q. Doctor, in your experience has evidence-based medicine become accepted in the medical community?

* * * * *

[895]

A. Well, ultimately, studies or data that is collected in the interest of evidence-based medicine has to be disseminated to the medical community in some way. And it is through publication and peer-reviewed journals that that is done.

Q. Now, doctor, we have been mentioning several different types of studies that are used under the rubric of evidence-based medicine. Are these the types of studies that are done to test the development of new surgical procedures?

A. Yes.

Q. Are these the types of studies that are done in the field of obstetrics and gynecology?

A. Yes.

Q. Doctor, could you comment on what role, if any, intuition plays under the rubric of evidence-based medicine?

A. Well, intuition really relates to a physician or for an individual developing or suggesting how improvements can be made in treatments or in diagnosis and so forth.

You intuitively say: "This might improve the outcome in this particular disease." And that's the way these new techniques, operative procedures, medications are often developed, by intuitively using one's

experience and intuitively deciding how it might be done better.

Q. Doctor, do you have an opinion as to whether a physician's [896] intuitive judgment about a technique's safety, for example, is a reliable indicator of whether, in fact, that technique is safe?

A. It can't be the final arbiter of safety or efficacy. Once a new innovative procedure or medication or diagnostic technique is introduced it has to be subjected to more than a single intuitive recognition that this might be better. And that is where evidence-based medicine comes into play.

Q. And you just mentioned that an intuitive assessment has to be subjected to study. Can you just elaborate on that? Why is that your opinion?

A. Well, without such a study you may not recognize or you may not be able to ascertain how that particular intuitive knowledge will be—will apply to all situations. Let me give you—may I use an example of —in our own field of obstetrics and gynecology, it was intuitively—intuitively, we thought that doing a procedure called an "episiotomy" would be beneficial to pregnant women and their babies. Now, episiotomy is where the obstetrician makes an incision in the birth canal to allow more room for a baby to deliver. It was thought that would protect women from more severe lacerations or injury to the birth canal. For years, almost 30 or 40 years, it was routine, particularly in women having their first infant, to make this incision called an episiotomy, until finally this was subjected to a modern [897] Evidence day techniques and scrutiny. And a large—in fact, there have been several large randomized controlled trials, as I described them,

where women were asked to participate and agreed to either have an episiotomy performed when their baby was born or to have no episiotomy.

And lo and behold it turned out that having no episiotomy had a better outcome. Having an episiotomy led to more serious lacerations that resulted in things such as rectal incompetence.

And that was a rather astounding finding, but it showed that intuition was entirely misleading. And it took an elegant study to actually teach us otherwise. Now, episiotomies which were done almost routinely in the past are now done only in selected patients, and there are indications for it.

Q. Doctor, are you aware of any other examples in the field of obstetrics and gynecology where an intuitive judgment that a procedure was safe has been disproven after that procedure was subjected to study?

A. Yes, fetal heart rate monitoring would be an example. The study of breech delivery would be an example where these techniques initially were thought to be of great value and have certain efficacy and safety that was proven not to be true when subjected to a randomized controlled trial.

Q. Doctor, now, going back a little bit, I think you mentioned * * *.

* * * * *

[908]

Q. Doctor, do you have an opinion as to whether these case series establish the comparative safety of the intact D&X procedure as compared to the disarticulation D&E procedure?

A. Yes.

Q. What is your opinion?

A. My opinion is that these do not establish the relative safety of these procedures.

Q. Can you just elaborate on your opinion a little more?

A. Well, simply because they are not compared to anything, they are not compared to a comparable group of patients in the—so you don't know whether they are a greater safety, lesser safety, less efficacy, greater efficacy unless you have a comparison group. Now, in one case, I believe Dr. McMahan or Dr. Haskell said related to other procedures as reported in the literature, but you actually have to go beyond that because those were quite different settings, quite different populations of patients, so you don't really have the kind of comparison you would want in an epidemiologically sound retrospective study.

Q. Now, doctor, we have been talking about the absence of published peer-reviewed studies comparing the safety of the intact D&X procedure with the disarticulation D&E. During the course of this case have you become aware of any unpublished studies that compare the safety of the intact D&X procedure * * *.

* * * * *

[912]

Q. Doctor, turning your attention to the fourth page, or page 4 of the Chasen Study.

A. I have it.

Q. Left-hand column in the middle of the page, the paragraph beginning, "Our approach." And it reads:

"Our approach in performing intact dilation and extraction whenever possible is intended to minimize the use of forceps in extracting the fetus. We believe that the use of forceps to grasp the fetus can cause inadvertent trauma to the uterine wall at these gestational ages evacuation of a fetus can require multiple insertions of forceps and intact dilation and extraction avoids this."

Do you see those sentences, doctor?

A. Yes, I do.

Q. Doctor, does the data recorded by the authors of the Chasen Study support the safety advantages that are set forth in that paragraph?

A. No, it doesn't.

Q. Doctor, you testified that having reviewed the expert reports submitted by the experts in this case and in the Nebraska and New York cases you're aware of a claim being made that the intact D&X procedure offers safety advantages over the D&E procedure because it results in a shorter procedure; is * * *.

* * * * *

[919] seen? And that gets to the point of: did they overlook complications that weren't included in the data itself?

In other words, a patient may have had a complication and went to another hospital or another facility for treatment, so we don't know how well they followed up those patients. Perhaps they got all of them, but you should say something about that.

Q. You just mentioned the follow-up for surgical procedures. Any—outside the your concern about or limitation of describing the follow-up for surgical procedures, are there any other methodological limitations?

A. Well, on which the authors readily admitted was in their follow-up of patients who had subsequent pregnancies—first of all, there were very few pregnancies. And they admitted that not all of those patients came back to their facility for obstetrical care. And they used only their own medical records.

So we don't know how many other patients had pregnancies, and had pregnancies—or what the outcomes of those were. So they are basing their conclusion that there was no difference in premature birth on a far too small proportion of the patients that actually had the abortion procedures and those with inadequate follow-up.

So I think they—that was not justified to make that conclusion.

* * * * *

[922]

A. Well, he may have disclosed it, but it is not disclosed—it's not disclosed in the final proof. This would be the article that the readers would see. The readers would have no idea of his involvement.

Q. Doctor, I believe you testified—and I am going back again, having read the expert reports of the plaintiffs in this case and in the Nebraska and New York cases—that you're aware of the claimed safety advantages of the intact D&X procedure as compared to the D&E procedure, and that those alleged safety

advantages include the fewer number of passes into the uterus, the shorter procedure time and less blood loss, and the less risk that a part of the fetus will remain in the uterus.

Do you have an opinion about the validity of those claims from an evidence-based medicine perspective?

A. Yes.

Q. What is that opinion?

A. I don't think those claims have been established with good medical evidence as of now.

Q. Doctor, do you think—do you have an opinion as to whether it would be feasible to construct a study comparing the intact D&X procedure with a D&E procedure?

A. I think it would be feasible.

Q. What kind of studies could be done?

A. Although they are not easy to do in this setting, you could * * *.

* * * * *

[WATSON BOWES, JR., M.D.—CROSS EXAMINATION]

[943]

* * * * *

I would like to start, Dr. Bowes, by talking to you about how a physician chooses the appropriate abortion method for his or her own patient.

You would agree, doctor, that in starting an abortion procedure, whether it be an induction, a D&E, an intact D&E or some other procedure, that the

physician's intent is to end the pregnancy in the way safest for the woman, wouldn't you?

A. Yes.

Q. And you would agree that the safest and most appropriate abortion procedure for a particular woman depends, in part, on the gestational age of the pregnancy?

A. Yes.

Q. And you would agree, also, that the safest and most appropriate abortion procedure for a particular woman depends, in part, on her underlying health?

A. Yes.

Q. And you would also agree that the safest and most appropriate abortion procedure for any individual woman would depend, in part, on any medical contraindication that she might have?

A. Yes.

[944]

Q. And you would agree that the safest and most appropriate abortion procedure for a particular woman depends, in part, on her prior surgical history, if any?

A. Yes.

Q. And you would agree the safest and most appropriate abortion procedure for a particular woman depends, in part, on the training, skill and experience of her physician?

A. Yes.

Q. And you would agree, also, that the safest and most appropriate abortion procedure for any particular woman depends, in part, on whether she or her doctor

desires to remove the fetus intact to permit complete pathological testing.

A. Yes.

Q. And you would agree that with respect to a medical emergency exception to an abortion restriction a physician should be permitted to rely on his or her own best medical judgment to determine if there is such an emergency?

A. Yes.

Q. Now, I would like to switch a little bit and talk to you specifically about D&E abortions. Would you agree with me in a D&E if removal of the fetus can be accomplished with fewer rather than more instrumental passes that that would be helpful?

A. Intuitively, yes, I would agree with that.

[945]

Q. And would you also agree that when a physician performs a D&E he or she is trying to do so with as little trauma and blood loss as possible for the woman; is that right?

A. Yes, I would agree.

Q. And he or she tries within the bounds of safety to complete the procedure as quickly as possible; is that correct?

A. Yes.

Q. And would you agree the physician tries to insert the forceps into the uterus as few times as possible in order to complete the procedure?

A. Yes.

Q. And I think that you alluded to this in your prior answer, but you would agree intuitively, even if not conclusively, that a technique that reduces the number of insertions of instruments into the uterus might offer some safety advantages?

A. Yes.

Q. And you agree during the course of a D&E it might happen on some occasion that the physician is able to extract the fetus up to the calvarium with one pass of instruments into the uterus?

A. Yes.

Q. Do you agree that the risks of D&E increase as gestational age advances?

A. Yes. I think there is evidence that it does.

Q. And if you had two large groups of women having D&E's, one [946] group having them at 20 weeks and one who was having them at 22 weeks, would you expect to see more complications in the 22 Week group?

A. Intuitively, yes, you would.

Q. You agree, don't you, that overall D&E is a safer procedure than induction?

A. I believe it's been established that it is.

Q. And that's part based on the data of the Centers for Disease Control?

A. Yes.

Q. And it's also, in part, based on the research of Dr. Grimes?

A. Yes.

Q. And I think you have testified to this, but you know Dr. Grimes well, don't you?

A. I do.

Q. And he is on the faculty at your institution; is that correct?

A. Yes, that's correct.

Q. And he's a well-respected practitioner, isn't he?

A. Yes, he is.

Q. And he's also a very competent researcher?

A. Yes, he is.

Q. And I think you also alluded to this on your direct, but you agree that there is evidence that women prefer D&E to [947] induction abortions because D&E abortions do not require the women to be in labor; is that correct?

A. Generally, that is correct, yes.

Q. And you would agree that there are certain contraindications for induction in the second-trimester of pregnancy?

A. Yes.

Q. And one of those would be a classical uterine scar or a myomectomy? A scar from a myomectomy.

A. A scar from a myomectomy, yes, ma'am.

Q. And a myomectomy is surgery to remove uterine fibroids; is that correct?

A. Yes, that's correct.

Q. And do you believe that retained placenta is a complication of induced abortion?

A. Yes.

Q. I am sorry. And that is specifically of induction abortions. I misspoke. It's a complication of induction abortions?

A. Yes.

Q. And would you agree that on rare occasions induction abortions may not always be successful?

A. On rare occasion, yes.

Q. And on those rare occasions, if it is not successful, the physician may have to perform a separate surgical procedure in [948] order to complete the abortion; is that correct?

A. That's correct.

Q. And would you agree that at 20 or 21 weeks the uterus usually doesn't contract spontaneously, or if it does, the contractions are sporadic and don't cause cervical dilation?

A. In general, that is correct, yes.

Q. And would you agree that the drugs used in induction abortion to cause uterine contractions override that process?

A. Yes, they do.

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[957]

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Q. Sure. Would you agree that some prospective trials the purpose is to look at a specific intervention or treatment in the general population?

A. Yes.

Q. And those are often a first step in establishing the safety of an intervention or treatment; is that correct?

A. Now, if you mean by "prospective trial" the randomized trial that I have described?

Q. Yes.

A. And if you mean by "general population" the population of individuals that have the condition or treatment, yes.

Q. Yes.

And isn't it the case if a potential participant in one of those trials has a very serious health condition which is unrelated to what is being studied, that he or she might be excluded from the study?

A. Yes.

Q. In fact, I don't know if you remember, but in the Lancet study we were just talking about, multiple gestations were excluded; is that correct? And women with a gestational age less than 37 weeks were excluded; is that correct?

A. Yes.

Q. And if the fetus was judged to be clinically large or to have an estimated fetal weight of 400 grams or more they were [958] excluded?

A. Yes.

Q. And if there was a fetal anomaly or condition that might cause a mechanical problem at delivery, such as hydrocephalus they were excluded?

A. I am aware of that, yes.

Q. And that is typical in general safety studies to exclude people with conditions?

A. Yes.

Q. That are unrelated to the treatment, correct? Yes?

A. Yes.

Q. So is it fair, then, to say that a prospective randomized trial such as that would not tell you how the treatment or intervention being studied would be tolerated by a person with one of those medical conditions that is not the subject of the study?

A. If in constructing the study you eliminated certain patients, indeed, the study would not apply—the results of the study would not apply to those patients who had been excluded.

Q. And even then if the study showed that that treatment or intervention had certain advantages in the general population, it might be the case that people with a certain serious underlying medical condition should not have that treatment; isn't that true?

[959]

A. That's true.

Q. And by the same token, if that sort of trial demonstrated a treatment or intervention did not benefit the general population, it still might be better for any specific patient with a specific health condition; isn't that right?

A. I think that is right. There are a lot of conditions there.

Q. Do you want me to repeat it?

A. No, ma'am. I think I understand it.

Q. You offered some testimony about the safety advantages or whether or not there were safety advantages about D&E abortions where the fetus is removed intact up to the calvarium. Have you ever personally observed or supervised a D&E where the fetus was removed intact up to the calvarium?

A. No, ma'am.

Q. And you've never spoken to any physician who performs intact D&E's about those abortions, have you?

A. No.

Q. And the only materials you reviewed to prepare your original expert report were Dr. Paul's textbook, the Haskell paper that you were just looking at, and another nonpublished paper; is that correct?

A. As relates to the abortion aspects. I reviewed other things because the questions went beyond that to such things as the incidence of neonatal death after late gestational age.

[960]

Q. Those were the only materials that related to removal of a fetus intact during a D&E; is that correct?

A. Yes.

Q. And despite that you have Dr. Grimes, who is an expert on induced abortion at UNC, you haven't spoken to him about his opinions about intact D&E, have you?

A. No, I have not.

Q. You actually haven't spoken to him about his opinions about D&E abortions, either, have you?

A. I don't think I have spoken to him directly. I happen to know his literature well, and he's written extensively about it, so I think I have some idea about what his impressions are.

Q. Would you agree with me, Doctor, though, that there is a body of medical opinion which consists of responsible group of physicians that hold the opinion that intact removal of a fetus during a surgical abortion may be the safest procedure for some women in some circumstances?

A. Yes.

Q. And you would agree that there is no consensus in the medical community that removal of the fetus during a D&E is never medically necessary; is that right?

A. That's correct.

Q. And you've offered some criticisms of Dr. Chasen's study today, but it is not your view that his study is of no use, is it?

[961]

A. No, that is not my view.

Q. Indeed, you believe that his study would help a physician design a prospective randomized trial; isn't that right?

A. Yes.

Q. And would you agree with me that a study like Dr. Chasen's is often the first step in the process towards a randomized controlled trial?

A. I would agree with that.

Q. And leaving Dr. Chasen's study aside, you believe that a very credible, respective cohort study could be conducted comparing D&E where the fetus is removed intact to where the fetus is removed in a D&E by disarticulation?

A. Yes, I believe that.

Q. And that study would be very similar to Dr. Chasen's, right?

A. Yes.

Q. And you believe that a properly conducted study such as that is a valid and acceptable basis on which a particular procedure could become widely used in the population, don't you?

A. I do.

Q. And I am correct, aren't I, that you can't properly conduct a retrospective case controlled study until the technique has been used in an appropriately large number of cases?

[962]

Q. And in order to conduct that study, some passage of time must occur after the technique is introduced so that a sufficient number of those cases have occurred; isn't that correct?

A. That's correct.

Q. And that period of time could be years; is that right?

A. Yes.

Q. And the period of time would depend on the facts and circumstances of the actual technique that is involved in the study; isn't that correct?

A. That's correct.

Q. And you agree that if a procedure is outlawed before it has been performed that number of times, then such a study could never be conducted; isn't that right?

A. Well, it couldn't be conducted in areas where the procedure was outlawed.

Q. And do you want to explain what you mean by that?

A. Well, in another setting you might be able to perform a study of these two procedures where the procedure had not been outlawed.

Q. If it was outlawed in the United States, would the only way to study it would be to do it in another country?

A. Yes, or alter the procedure in some way so you modify the procedure so it would not—it would not violate the law, if there was a law, although you would not be studying the [963] original procedure on a live baby. You would not be actually doing a study on abortions of live infants. Live fetuses. Excuse me. Live fetuses.

Q. And is the reference to a "live fetus" something about the law at issue in this case?

A. Yes, I believe it is.

Q. And can you explain what you mean by modifying so you don't have a live baby?

A. Well, there are certain abortion procedures in which physicians inject medications that intentionally kill the fetus prior to an abortion procedure. So that you now have a fetal death.

And it is my understanding that these restrictions do not apply to situations in which the fetus is not alive, is dead.

Q. Okay. I would like to ask you some questions about the injection of the chemical agent that you have referenced.

In the few D&E abortions that you have performed since your residency where the fetus was alive at the outset, you didn't inject either potassium chloride into the fetal heart or digoxin into the amniotic sac to cause fetal demise before you began the procedure, did you?

A. No, I did not.

Q. And you agree that there is no medical benefit to the woman from injecting those substances in order to cause fetal demise; [964] Isn't that correct?

A. I agree with that.

Q. In fact, you would agree that there are risks to the woman even if those risks are very small associated with those injections?

A. Yes, I agree.

Q. And that there is no medical reason to subject the woman to those risks?

A. That's correct.

Q. And you would agree that those indications can't be given to all women in all situations; is that correct?

A. Those medications?

Q. Yes.

A. I agree with it, yes.

Q. For example, it would be more difficult to use those injections on a morbidly obese woman; isn't that right?

A. That's correct.

Q. Speaking specifically about injections of potassium chloride into the fetal heart, you would agree, would you not, that all physicians do not have the skill to perform that injection?

A. I agree with that.

Q. In fact, when you prepared your expert report, counsel for the defendant asked you to state in that report that it is easy to administer potassium chloride into a fetal heart and you [965] felt that was not an appropriate statement; is that correct?

A. Correct.

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[967]

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Dr. Bowes, was a draft of your expert report prepared by counsel for the defendant in this case?

A. Yes, it was.

Q. And did that draft include the phrase that it is easy to administer potassium chloride into a fetal heart?

[968]

A. Yes.

Q. And did you remove that from your expert report?

A. Yes.

Q. And was the reason that you removed that is because you didn't think it is appropriate?

A. Yes. I don't think it is easy.

Q. In fact, you believe that one needs expertise to administer potassium chloride into a fetal heart; is that correct?

A. Yes, I do.

Q. You yourself have never done that?

A. That's correct.

Q. Nor have you taught your students to do it?

A. That's correct.

Q. And at the University of North Carolina, potassium chloride injections are given only by maternal fetal medicine specialists and not by the attending ob/gyn; isn't that right?

A. That's correct.

Q. Turning to digoxin, you have never personally used or observed digoxin being used to cause fetal demise, have you?

A. I have not.

Q. And you would imagine, wouldn't you, that in a woman with severe heart disease you might want to avoid the use of digoxin; isn't that true?

A. Yes.

Q. And you agree that nausea and vomiting are known side [969] effects of digoxin?

A. I am aware of that.

Q. And you agree that all things being equal, the physician would like to avoid those sort of unpleasant side effects when possible?

A. Yes.

Q. And before we moved to this topic we were still talking about how you could perform a retrospective case controlled study.

And would you agree with me that as long as there isn't a high rate of complications from a new technique or variation of a technique that until there is a sufficient number of times in which it has been performed, such that it can be properly studied, it is appropriate to leave its usage to the informed judgment of responsible physicians?

A. Yes.

Q. Your primary criticism of Dr. Chasen's study is that it doesn't have sufficient patients, and therefore it doesn't have the power to prove that there is no difference between the D&E with disarticulation versus the intact D&E group; is that correct?

A. That's correct.

Q. But you yourself haven't figured out how many D&E's where the fetus was removed intact versus where the fetus was dismembered you would need in order for to you consider it [970] reliable, have you?

A. I have not done what is called a formal power analysis to know precisely how many patients would be required.

Q. Would you agree that an epidemiologist might be more of an expert in assessing the number of patients needed in order to make that kind of study reliable?

A. A biostatistician would conduct that kind of—conduct that kind of analysis.

Q. And he or she would have more expertise than you in doing that?

A. That's correct.

Q. Would you agree that if a retrospective study is published in a well-respected peer reviewed journal that the process of peer review at least provides some assurance that the study had been responsibly and reliably conducted?

A. Some assurance.

Q. That is one of the purposes of peer review, is it not?

A. Yes, it is.

Q. Another criticism that you have with dr. chasen's study is that you believe there was insufficient follow-up with the patients; is that right?

A. I believe that the follow-up was not adequately described. I don't know how—you just don't know about it.

Q. Might follow-up with patients be a problem in many retrospective studies?

[971]

A. Yes.

Q. And that wouldn't necessarily be unique to Dr. Chasen's study?

A. No.

Q. I believe the opinion that you're expressing today is that Dr. Chasen's study doesn't demonstrate

the superiority of D&E where the fetus is removed intact versus where it is dismembered; is that correct?

A. Yes, that's correct.

Q. But you would agree, would you not, that Dr. Chasen's study certainly does not suggest that D&E where the fetus is removed intact is any less safe than where the D&E is disarticulated?

A. I am aware of that.

Q. And you are not aware of any evidence-based medicine that establishes that the removal of the fetus intact during the D&E is less safe than a D&E with disarticulation, are you?

A. I am not aware of any.

Q. And you are not aware of any study that establishes that removal of the fetus intact during a D&E is any less safe than an induction abortion, are you?

A. I don't know of any study that has compared those.

Q. You would not say that a hysterotomy in all but very rare circumstances would be preferable to a D&E where the fetus is removed intact, would you?

A. Could you repeat that, please?

[972]

Q. Sure. You wouldn't say that a hysterotomy in all but a very rare circumstance would be preferable to doing a D&E where the fetus is removed intact, would you?

A. I would not say that. I mean, I think I agree with what you just said.

Q. You would agree that in most cases an intact D&E would be preferable to a hysterotomy?

A. Yes.

Q. And you agree there is no reliable medical basis upon which to say that intact removal of a fetus during a D&E is any more dangerous to a woman than any other abortion method; isn't that right?

A. I believe that data is not available.

Q. So in some ways—if I am mischaracterizing your testimony, please correct me—the bottom line of your opinion is really that there's no evidence-based medicine that you deem reliable either way about the safety of D&E where the fetus is removed intact; is that right?

A. That's correct.

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[974]

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Q. I would like to talk to you about the findings of the Partial-Birth Abortion Ban Act.

MS. KRASNOFF: May I approach the witness?

THE COURT: Yes.

BY MS. KRASNOFF:

Q. This is Plaintiff's Exhibit 1. Dr. Bowes, if you would take a look at Dinding Number 2, which is on the first page of this document. Do you see that?

A. Yes, ma'am.

Q. That finding states, quote:

[975]

"Partial-birth abortion remains a disfavored procedure that is not only unnecessary to preserve the health of the mother, but, in fact, poses serious risks to the long-term health of women, and in some circumstances their lives," unquote.

You don't agree with that finding, do you?

A. I don't. I do not.

Q. And, in fact, no valid scientific evidence supports that finding, does it, Dr. Bowes?

A. Not in my view.

Q. If you could turn to page 4, which is marked S3-4. And you can read finding 14(A) to yourself. That is quite long. If you could let me know when you have finished.

A. I have read it.

Q. And, Dr. Bowes, there is no reliable scientific evidence that demonstrates that partial-birth abortion poses any of the risks enumerated in that finding on a more serious or frequent basis than any other abortion procedure, is there?

A. Not that I know of.

Q. And if you could flip the page to page 5 and take a look at finding 14(F). Do you see that? It actually just says "F" because the "14" is on the previous page.

A. Okay.

Q. That states, quote:

[976]

"A ban on the partial-birth abortion procedure will therefore advance the health interests of pregnant women seeking to terminate a pregnancy."

In your opinion, Dr. Bowes, there is no valid, reliable scientific evidence that supports that statement, is there?

A. I believe there is not.

Q. And, in fact, your support for the partial-birth abortion ban act of 2003 is not based on any concerns for protecting maternal health, is it?

A. No, I don't think those have been established.

Q. Rather, your support for the Act is based on your ethical opposition to abortion in general and particularly to intact D&E being performed post-viability other than to save the life of the woman; is that correct?

A. That's correct.

Q. And your ethical opposition to abortion procedures pre-viability is not in any way particular to the intact D&E procedure as opposed to other methods of abortion; is that correct?

A. That's correct.

Q. And you would support a ban on all abortions as long as it contained an exception for when the woman's life was at risk, would you not?

A. Yes, I would.

[977]

Q. And isn't it true you would not perform an abortion to save the life of one of your patients unless

you were satisfied that the likelihood that she would die is more than 50 percent?

A. Yes.

Q. Would you agree with me that in any given case other physicians might disagree about that percentage or what the likelihood is that a woman might die?

A. Yes.

Q. And you would favor a ban on abortions even in cases where the pregnancy was the result of rape and incest; isn't that right?

A. I have stated that, yes.

Q. I want to clarify one thing from your direct testimony, which is that you stated that the term "partial-birth abortion" appeared in the new England Journal of Medicine. Am I correct that that was in a letter that was written?

A. No.

Q. It was—was it in an article that was peer reviewed?

A. Well, it was an—the article I am recalling was not a study, that is a scientific study. It was a description of the procedure and the implications of the legislation, and so forth, that was being described.

But it was—in fact, I think the title of it was "Partial-birth abortion."

Q. And—

[978]

A. So those types of articles are not subject to peer review. These are decisions made by the editors to—but not necessarily subjected—the manuscript has not

been subjected to peer review. These are commentaries.

Q. So just to be clear, this was not subjected to peer review; is that correct?

A. That's correct.

Q. Going over some of your experience with abortion procedures, your only formal training in abortion techniques was during your residency which was between 1962 and 1965; is that right?

A. That's correct.

Q. And the only second trimester abortion method that you received training in during your residency was the induction method; is that correct?

A. Yes.

Q. And you were not trained in the dilation and evacuation or D&E procedure during your residency; is that right?

A. That's correct.

Q. And that's because D&E wasn't being performed in Colorado in the 60's, right?

A. That's correct.

Q. And you haven't received any formal training on abortion techniques or procedures since being 1965; is that right?

A. That's correct.

[979]

Q. And in the close to 40 years since you completed your residency you have only participated in between four to six to 10—fewer than 10—second-trimester

abortions where the fetus was alive at the beginning of the procedure; is that correct?

A. That's correct.

Q. And you yourself did not perform these abortions; is that correct?

A. No, I was supervising the abortion with the resident.

Q. So you supervised them, right?

A. Yes.

Q. And in none of these five to 10 induced abortions that you supervised did the fetus have a gestational age that was greater than 20 weeks LMP; is that right?

A. I believe that's correct, yes.

Q. And you testified on direct that of the 10, only two or three were actually by the D&E method; is that right?

A. That's correct.

Q. The remaining seven or eight were by induction?

A. Yes.

Q. Given the fact that you haven't performed any yourself and have supervised two or three D&E's on fetuses that have not naturally demised, would you experience your experience in D&E's on a live fetus is quite limited?

A. I would agree.

[980]

Q. I forgot to ask you this, but you have never personally observed or supervised a D&E where the

fetal was removed from the uterus intact up to the calvarium?

A. I have not.

Q. And you testified you've been involved in the performance of 150 second-trimester abortions on fetuses that have already demised before the procedure had begun; is that correct?

A. Yes. Those aren't technically called "abortions," but they are pregnancy terminations in the situation of fetal death.

Q. Those 150 were over a 40-year period; is that right?

A. Yes.

Q. And most of those were done by induction; is that right?

A. Yes.

Q. In fact, approximately one or two per year that were done using the D&E method; is that right?

A. That's correct.

Q. And in the one—in the two D&E's per year that you were involved in, the resident was actually performing the procedure and you were supervising; is that right?

A. That's correct.

Q. And sometimes in these situations of fetal death, the fetus would have been dead for hours before the procedure began; is that right?

A. Yes.

Q. And sometimes the fetus had been dead for a day or more [981] before the procedure began; is that correct?

A. Yes.

Q. And the passage of time after demise changes the nature of the fetal tissue; does it not?

A. Yes, it does.

Q. And am I correct that that process is called "maceration"?

A. Yes.

Q. And you would agree that following a fetal death the composition and consistency of the fetal body is different than it was than when an abortion was begun on a living fetus; would you not?

A. Yes.

Q. And you agree that there are some differences in the case of fetal demise in an induction abortion compared to when the fetus is living at the outset; is that right?

A. Could you restate that? I am not—I want to be sure I understand that question.

Q. Sure. Are there any differences in an induction abortion between when it is—in your experience—between when it is done on a living fetus and when it is done on a fetus that has been demised for a day or two?

A. I am not sure that that is true or not. I don't know that that really has been studied. In my experience, the labor is pretty much the same in both of those situations.

Q. In your experience the uterus is equally responsive [982] whether—to the inducing agents, whether the fetus is alive or not?

A. In my experience, yes.

Q. And you've never taught abortion didactically, have you?

A. Not by "didactically" if you mean in lecture and some such things, no. I have taught abortion procedures to and the techniques for performing the various things that we have described to residents in clinical settings, if that is what you mean. If I can qualify that by you what mean by "didactic."

Q. That's fine. You testified that you sit on an institutional review board at the University of North Carolina. None of the research projects that have come before you as a member of the Institutional Review Board have involved abortion, have they?

A. Not that I recall, no.

Q. You have not authored any articles about abortion procedure, have you?

A. No, I have not.

Q. And you haven't conducted any peer review for any journal with respect to any articles about abortion procedure, have you?

A. No.

Q. And you have not participated in, conducted or been otherwise involved in any studies of any method of abortion [983] procedure, have you?

A. I have not.

Q. And you retired from the practice of medicine in 1999, I believe you said?

A. I did.

Q. And I assume I'm correct that would mean you haven't performed any abortions on demised fetuses, or otherwise, since that time; is that correct?

A. That's correct.

Q. Dr. Bowes, is it not true that when you were first asked in your deposition if you considered yourself to be an expert on abortion or abortion technique that you responded "no"?

A. That I responded "no" when I was first asked?

Q. Yes.

A. I don't recall exactly what I said, but I am not an expert on abortion techniques.

Q. And you also agree you are not an expert on induced abortion at all; is that right?

A. I am not considered an expert on induced abortion.

Q. And you would agree that someone who has more experience performing induced abortions than you do would have greater expertise in that area, do you not?

A. Yes.

Q. And, Dr. Bowes, this is not the first case regarding an abortion restriction in which you have offered an opinion in [984] favor of that restriction, is it?

A. No, this is not the first case.

Q. In fact, you have many times been an advocate for other restrictions and prohibitions on abortions; is that correct?

A. Several times.

Q. You've offered some sort of sworn testimony in six different cases where a state had banned what they called "Partial-birth abortion"; is that not correct?

A. Yes, that's correct.

Q. And you've testified uniformly in support of those bans, have you not?

A. Yes.

Q. And, in particular, you offered testimony in support of Rhode Island's ban on partial-birth abortion?

A. Yes.

Q. And Wisconsin's?

A. Yes.

Q. And West Virginia's?

A. Yes, ma'am.

Q. And New Jersey's?

A. Yes.

Q. And Virginia?

A. Yes.

Q. And last one, Montana; is that correct?

A. Yes.

[985]

Q. And in each of those six cases you opined that the ban did not pose a threat to the women's health; did you not?

A. Yes.

Q. And you also find that the ban did not reach either D&E or induction abortions in either of those cases, did you not?

A. Yes.

Q. Now, you testified on direct that you sent a letter to Representative Canady in 1995 expressing your support for a previous version of the federal Partial-Birth Abortion Ban Act; is that correct?

MR. QUINLIVAN: Objection. Mischaracterizes his testimony.

THE COURT: I will allow the question. He can clarify.

THE WITNESS: My letter to Doctor—excuse me—to representative Canady was in response to specific questions about assertions that had been made regarding the Act. So I—if I recall my letter correctly, it was only responding to those several questions. Such things as neonatal survival at various gestational ages, assertions that all the fetuses were dead that had received analgesia the mother—analgesia given to the mother always kills the fetus, and such things as that.

I simply responded to that.

BY MS. KRASNOFF:

Q. And was your letter in 2003 in support of the current [986] version of the ban to Senator Santorum, was that also simply responding to questions that were asked of you?

A. Yes. I think Senator Santorum, the question related to assertions made by Dr. Philip Darney about this procedure.

Q. But no one in Congress sought your opinion on whether you thought the findings in the bill were accurate or not, did they?

A. No, they did not.

Q. If they had would, you have told them what you told us here today, that they were not accurate?

A. Yes.

* * * * *

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C 03-4872 PJH

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. AND PLANNED PARENTHOOD GOLDEN GATE, PLAINTIFFS

v.

JOHN ASHCROFT, ATTORNEY GENERAL OF THE UNITED STATES, DEFENDANT

TRANSCRIPT OF PROCEEDINGS
Apr. 9, 2004
Volume 7

BEFORE THE HONORABLE
PHYLLIS J. HAMILTON, JUDGE

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* * * * *

[L. LEROY SPRANG, M.D. - DIRECT EXAMINATION]

[1000]

THE WITNESS: I do.

THE CLERK: Take the stand.

THE WITNESS: Thank you.

THE COURT: Good morning.

THE CLERK: Please state your name for the court.

THE WITNESS: M. Leroy Sprang. L-E capital R-O-Y, S-P-R-A-N-G.

BY MR. SIMPSON:

Q. Dr. Sprang, how are you this morning?

A. Well, thank you.

Q. What is your medical specialty, doctor?

A. I am a board certified in obstetrics and gynecology.

THE COURT REPORTER: Is the microphone on?

THE CLERK: Yes.

THE COURT: Your voice is—

THE WITNESS: I have a very soft voice. If this doesn't work—

THE COURT: Well, it is on. It doesn't amplify very loudly. I will ask you to sit close to it. That's fine.

BY MR. SIMPSON:

Q. Doctor, you said you are board certified in obstetrics and gynecology?

A. Correct.

Q. Briefly, doctor, could you tell us what your actual medical [1001] practice consists of?

A. I have a full-time private academic practice at Evanston Northwestern Healthcare. I provide—can you hear me? Barely?

THE COURT REPORTER: Barely. You provide?

THE WITNESS: I provide full gynecologic services. I've delivered 3,000 patients, and done numerous surgical procedures.

BY MR. SIMPSON:

Q. So do you do a full range of obstetrics and gynecology?

A. I do a full range of obstetrics and gynecology, yes.

Q. You mentioned practicing at Evanston Northwestern Healthcare is that a hospital?

A. It is actually a hospital system. We have three hospitals, and it has a large geographic area with 1800 physicians on staff.

Q. Where is Evanston, doctor?

A. Evanston is a suburb directly north of Chicago.

Q. For how many years have you been practicing obstetrics and gynecology?

A. I have been in private practice for 28 years, and actually started training in obstetrics and gynecology in 1968.

Q. Doctor, have you held any faculty positions in medicine?

A. I am currently an associate clinical professor at Pritzker School of Medicine, Northwestern University. I have held other [1002] positions. I have been chairman of the division of obstetrics and gynecology for the National Center for Continuing Medical Education.

Q. Doctor, how long have you been associate clinical professor?

A. I have gone through—well, I will say about the last five years I was an assistant professor before that and instructor before that, so I have gone through each of the steps for a full professor.

Q. So when did you start your teaching?

A. I started teaching as a resident and started teaching medical students probably in 1972.

Q. And you said you're an associate clinical professor at Northwestern University?

A. Correct, Northwestern University has two major teaching hospitals, one downtown, Prentice Hospital, and the other in Evanston called Evanston Northwestern Healthcare.

Q. What do you teach at Northwestern, Doctor?

A. I have medical students and residents with me on a continuous basis, both in the office and in the hospital. So I am teaching the daily practice of obstetrics and gynecology. I teach surgical techniques, the full range of obstetric and obstetric practices.

Q. And I you mentioned the division of continuing —how did you say that?

[1003]

A. The division of continuing medical education. I— from about 1980, '81 to about 1997, I was chairman of the division of obstetrics and gynecology in a postgraduate continuing education course. I was putting on three to five actual postgraduate courses annually with hundreds of physicians from all over the United States and the world attending these classes.

And I was in charge of putting on the programs, picking both the topics and the speakers for about a 20-year period of time.

Q. Doctor, have you been an officer in any statewide medical organization?

A. Yes. Directly out of residency I became involved and also professional organizations both for the benefit

of our patients and our profession. I have gone through both in the department level each authorship, including President of Professional Staff at Evanston Hospital. I had authorships and chairmanships of the Illinois Medical Society and have been Chairman of the Board and President of the Chicago Medical Society. And I've had authorships and Chairman of the Board and President of the Illinois State Medical Society.

And I am a delegate from Illinois to the American Medical Association. And I am currently Chairman of the Illinois Delegation to the American Medical Association, and most recently Chairman of the Great Lakes States Coalition, |1004| which represents seven states to the American Medical Association.

Q. Doctor, when did you serve as President of the Illinois State Medical Society?

A. President in 2000, 2001; Chairman of the Board from 1996 to '98.

Q. Doctor, are you a member of any nationwide medical organizations?

A. I'm a fellow of the American College of Obstetricians and Gynecologists; have served in various formations and functions there. And currently interact with the American College of OB/GYNE delegation to the AMA. As being Chairman of the Illinois OB/GYNE we frequently will come together on issues related to women's health care and work together on those issues.

Q. When you say "OB/GYNE" do you mean obstetrician and gynecologists?

A. Yes. I can say that each time or I can say "OB/GYNE," whichever the court prefers.

THE COURT: "OB/GYNE" is fine.

THE WITNESS: It is just shorter.

BY MR. SIMPSON:

Q. Doctor, are you also—and you said you are a fellow—maybe I should go back. The American College of Obstetrics and Gynecologists, is that also known by the acronym ACOG?

[1005]

A. Correct.

Q. Are you a fellow of ACOG?

A. I am a fellow of ACOG.

Q. Are you also a fellow of the American College of Surgeons?

A. I am also a fellow of the American College of Surgeons.

Q. Doctor, is it your understanding that the majority of OB/GYN's are not fellows of the American College of Surgeons?

A. That is correct. It is a separate organization where you have to stand before a separate committee in order to be approved as a fellow of that organization, as well.

Q. Doctor, do you do any work in relation to medical liability insurance?

A. I also sit on the board of the largest liability insurance carrier in Illinois and actually have chaired that board, as well. We ensure 14,000 physicians in the state of Illinois. And we have practicing a thousand obstetricians and gynecologists, as a result review all of the liability cases in Illinois on a monthly basis in relation to those 14,000 physicians.

Q. Doctor, I believe you said that you are a delegate to the American Medical Association?

A. I am a delegate, have been a delegate for sometime, and now I chair the delegation. So I speak for the delegation at the AMA House of Delegates.

Q. Have you served on any committees of the AMA?

[1006]

A. I have served on several committees of the AMA. I have served on reference committees before the house on several occasions. I have served on different select committees that they have picked. I currently serve on the committee that selects the public member of the Board of Trustees of the AMA.

And I have recently—was selected for a special task force that they created to review intact D&X, and present that report back to the delegation, back to the House of Delegates.

Q. Can you tell us a little more, Doctor, about your service on that special committee regarding intact D&X? For example, how many physicians served on that committee?

A. There were a total of 10 physicians on that committee, nine appointed and the chairman of the committee was the chairman of the AMA Board of Trustees.

Q. So how were you chosen for that committee?

A. Resolutions were introduced to the interim meeting of the AMA in December of '96. And instead of voting up or down on those resolutions, the House felt it was an important enough issue to appoint a

committee, a task force, to review the issues and bring that report back in June to the annual meeting of 1997.

To be—to try to cover all the bases, representatives from ACOG, American Academy of Family Practice, and American Academy of Pediatrics, through the ethical and [1007] judicial committee and the Council on Scientific Affairs and two state representatives, one from Pennsylvania and one from Illinois were also selected.

And I was selected from Illinois to represent Illinois as a state representative on that task force.

Q. Why did they want to have an Illinois representative on the task force?

A. In the two resolutions that were brought forward to the interim meeting of the AMA came from Pennsylvania and Illinois. And because those states brought forward the resolutions they thought it appropriate to have a representative from each of those states.

Q. Doctor, have you done any work in the field of medical ethics?

A. I have been very involved in medical ethics at least for about the last 15 years. I did create the Ethical Committee for Evanston Northwestern Healthcare. I have been an invited speaker to national organizations on ethics of medicine, both national and regional at various levels. I have been a chairman of the Ethical Relations Committee for the Chicago Medical Society for the last 10 years, and had served on that committee prior to that.

I chaired the physician review committee for the Chicago Medical Society prior to that, and numerous

committees in the hospital. I have been in charge of quality assurance, [1008] audit, looking at ethical issues at hospital level and county level and the national level.

Q. Can you describe to us a little bit, doctor, a little more about what your service as chairman of the ethics committee of the Chicago Medical Society involves?

A. Sure. Either the Physician Review Committee, the Board of Trustees of the Chicago Medical Society or any other patient, insurance company or physician can file ethical charges against any member of the Chicago medical society. That would come before my committee. I would assess it. I would assign a couple other members of the committee to assess it.

If we felt there was sufficient data to go forward, we would then hold a hearing and actually bring that physician before the committee, review the material and then make decisions as to whether we thought it was ethically appropriate or not.

Then you have options of censure, probation or expulsion from the Medical Society.

Q. Doctor, I would like to show you what has been marked as defendant's Exhibit A-7 in this case.

Doctor, do you recognize that document, Exhibit A-7?

A. Yes, I do.

Q. What is that?

A. It is my current C.V.

Q. Is that a true and accurate copy of your curriculum vitae?

[1009]

A. Just checking to see how current it is, the last page. It does go to January, 2004, so it is rather current.

Q. Doctor, are the statements made in your C.V. correct?

A. To the best of my knowledge, yes.

MR. SIMPSON: All right. Your honor, I would like to move for the admission of A-7 into evidence.

THE COURT: Any objection?

MS. GARTNER: No objection.

THE COURT: All right, admitted.

THE CLERK: A-7 into evidence.

(Defendant's Exhibit A-7 was received in evidence.)

BY MR. SIMPSON:

Q. Doctor, are you familiar with the methods used by obstetricians and gynecologists in connection with terminating pregnancy?

A. Yes, I am.

Q. Could you just list for us at this point the ways that you have become familiar with those methods? Just list them for us now, and we'll ask you specific questions about them.

A. Clearly, I have been in private practice since 1975. I was resident before that, in medical school before that. And throughout that training had experience in various forms of abortions.

I was actually a medical student at Cook County, and [1010] we had numerous patients there, in

residency and in private practice, have been involved in abortions, abortion complications, taking care of patients who have had abortions, and my patients then returned to the office and took care of them.

So, experience, because of the extra emphasis on this area in about 1995 and '96 when it became more public knowledge, I got involved at our organization, the State Medical Society. We did literature research as to that. And the resolutions went to the AMA. As the chairman of the delegation, I was spokesperson for Illinois and had to do research on that.

I was later asked to write a journal article in JAMA, which is the most widely published medical journal in the world. And did significant research review in relationship to the article.

I was then asked to be an expert witness in the case in Ohio and did expert testimony there and again reviewed the literature and spoke with numerous other physicians, again, to present some of the programs.

There were a lot of physicians who I could discuss the issues with from across the United States. And then, I was asked to be an expert in this case. And so, again, I reviewed the literature up to the present.

And then, because of the involvement in this case I [1011] have been provided with probably dozens of declarations, depositions, articles. So I think I have a very thorough, up-to-date review and understanding of the procedures, the complications and have formed opinions on that basis.

Q. Doctor, you mentioned your own medical practice. Have you yourself had to remove the products of conception before pregnancy reaches term?

A. Yes, I have. As a practicing obstetrician, approximately 15 percent of all pregnancies have spontaneous abortions or miscarriages in the late term. Having done over 3,000 deliveries, if you take 15 percent of that, you are going to end up with about 450.

And those are both that occurred in the first-trimester, second-trimester and unfortunately even in the third-trimester.

I also because of I have such a large patient base, patients may get referred for abortions. And if they have issues will often come back to me because I am their primary doctor, they feel more comfortable. So I frequently will have to be involved in handling any complications in those procedures.

Q. Doctor, the instances when you have actually removed the products of conception before pregnancy reaches term, have all of those been instances in which the fetus had already died of natural causes or not?

[1012]

A. Essentially, yes. And in my expert testimony I did say each of the cases I was thinking of at the time the fetus had died. And actually talking about it and thinking about it more, there was an emergency situation where I was involved where a fetus had not died.

Q. Could you tell us about that case, please?

A. It was actually a patient came into the emergency room, and probably 10 years ago. That is why it wasn't at the top of my memory when I was first thinking about it.

She came into the emergency room. They called the general surgeons first. And she was actively bleeding intraabdominally. And so they knew she had

to go to surgery. And that was probably before the time of our instant data HCG's where we had instant data of that.

But they did a simple pregnancy test in ER, and it did come back positive. So the general surgeon said:

> "No one now. A gynecologist needs to go in there."

And so they called me, and I opened up and took her to surgery, because she was bleeding internally. I opened up her abdomen. And she was probably 10, 12 weeks pregnant. And sitting on the uterus was a pink, fleshy mass growing through the wall of the uterus.

And, again, I have a lot of experience. I'm a trained gynecologist. But I was certainly not sure of what [1013] this mass was. And I thought it was a sarcoma, a cancer of some kind. And we took off a piece of the tissue and sent it down for a frozen section. And it came back "placenta."

There is—I think different people know of different areas of the placenta. The placenta can, on occasion, rare occasion grow a little bit into the wall and be a placenta accreta.

Even more rarely it can grow into the wall. It is a placenta increta. And even more rarely the placenta, for some crazy reason, is so aggressive it actually grows through the wall and out the wall, which is what happened in this case. So it is an a placenta percreta.

You have got a life-threatening situation. The woman is bleeding. You have to—in that case I couldn't think of anything else to do other than actually do a hysterotomy, remove the placenta, which was growing

through the wall and suctioning out the uterine contents.

So I was doing an abortion on a live fetus to save the life of the mother. And the only other possible thing I could have done is do a hysterectomy, which would have left her without her uterus and no future possibility to conceive.

And in that circumstance, I felt it was in the best interest of the mother to do what I did.

And if the mother's life was at risk, that is the decision I would make. In that circumstance I did make that [1014] decision.

Q. So was the woman's uterus removed in that case?

A. The woman's uterus was saved, almost miraculously, because it was kind of a gutsy thing I wanted to do. I actually got—I was concerned about how well she would do postop and whether she would get infection or she would continue to bleed, because what I did was kind of unusual to take out part and leave part, but she did do very well.

And I did see her for a couple of years after that, then she moved out of state.

Q. Doctor, would a vaginal removal of the fetus have sufficed in that case?

A. Not at all, because the placenta had grown through the wall, so I would have—whatever I had to take out, that part of the uterine wall, with the placenta in it.

In those circumstances, it is like the placenta is almost acting like a cancer. It is not recognizing any boundaries, and it is just growing through the tissue.

Yet, it was supposed to be normal boundaries. It stops at the lining of endometrium. For whatever reason, in this case it just continued to grow through the wall.

THE COURT: Excuse me. Did the woman know she was pregnant?

THE WITNESS: I don't think so.

BY MR. SIMPSON:

[1015]

Q. Doctor, I believe you said this already, the fetus was alive?

A. The fetus was alive.

Q. But, of course, you said it was ten to twelve weeks, so the fetus did not live?

A. Well, actually, no, because I suctioned it out.

Q. It was previability?

A. Yes.

Q. All right. Now, doctor, aside from that particular case, can you list for us—you don't need to describe them at this point—but just list for us the method or methods that you've used to remove the products of conception.

A. Going through the gamut of typical procedures up to 12 weeks most of them are just suction curettage. Beyond 12, 13 weeks we would do variations of D&E's.

And most commonly in my practice beyond 18 to 20 weeks we would use induction.

Q. So, approximately—did you say you have used the D&E method?

A. Correct.

Q. Approximately how many times have you done that?

A. I am kind of giving a low estimate, because I haven't actually gone back and looked specifically. And I think in my expert report I said "maybe 20." I am sure it is actually more than that, but I was trying to be conservative rather than [1016] saying I did more than that.

Then if I talked about more after the 14 weeks, and actually the first-trimester stops in most people's textbooks at 12 weeks. So kind of the 13, 14 week is kind of a gray zone.

I was actually trying to say ones that were actually further advanced.

Q. Doctor, approximately how many times have you used the induction method to remove a dead fetus?

A. There are, unfortunately, many more than I would like. About 3 percent of women do have miscarriages in the second-trimester. And often you either do D&E's or inductions, depending on how far along they are. And there are sometimes stillbirth or intrauterine fetal demise at 20 to 25.

So that's—I said "20 to 30," but it depends on exactly what you count. Recently I have literally had unfortunately two that the baby died at 37, 38 weeks, which is a real tragedy. I am not sure if it's—it's obviously not second-trimester. It is third-trimester. So I am not exactly sure whether you want me to count those or not, but they are there.

Q. Let's include not just the second-trimester, but also the third on the induction method. So have you said 20 or 30 times you have used induction for that purpose?

A. At least.

[1017]

Q. Doctor, how would you compare the techniques used to remove the products of conception where the fetus has already died to the techniques used to do that where the fetus has not died?

A. The techniques are actually the same. And in reading the other depositions of other experts in this case, they don't make a distinction in whatever procedure they are using. Sometimes the physicians—"physicans"—sometimes the fetus is alive and sometimes it is not.

The more commonly in a procedure from reading all the depositions, more commonly that 26 to 27 week D&E's, D&X's are more commonly on dead fetuses. So they are doing the same thing.

MS. GARTNER: Your honor, I am not clear whether he is talking about his own practice or whether he is reporting on something from other people's depositions in this case.

THE COURT: Could you clarify?

THE WITNESS: Yes. I thought he asked me whether the procedures were the same, and I was saying:

"Yes, they are," and kind of showing that other people—yes, I believe they are. But in other deposi-

tions they are also—they are doing exactly the same procedure. So I think it just corroborates what I said.

THE COURT: Okay.

THE WITNESS: Yes?

THE COURT: I am a little unclear. You indicated [1018] you yourself have performed approximately 20 D&E's.

THE WITNESS: Correct.

THE COURT: And approximately 20 to 30 induced abortions, correct?

THE WITNESS: Yes, I am lowballing those numbers.

THE COURT: Fine.

THE WITNESS: Yes. Yes.

THE COURT: Let's say roughly about 50 in both categories? In both categories are we talking about cases in which the fetus had already died?

THE WITNESS: Correct.

THE COURT: All right. And the only instance involving a live fetus is the hysterotomy you described in the emergency room.

THE WITNESS: Correct. I have been involved in cases where patient comes into the emergency room maybe at 17, 18 weeks with an infection and is actually starting to begin labor on her own. And so you are taking care of that situation, and the fetus is alive. And you are starting, but you are still going to end up with a delivered fetus. Those are kind of more—you are in the process. There is infection of the uterus. It is usually contracting, anyway.

So you are in the process of just extracting the fetus during the process of what is really a labor process prematurely that the patient started.

[1019]

THE COURT: All right.

BY MR. SIMPSON:

Q. Doctor, you also mentioned having treated complications from abortion where women had received an abortion on a live fetus elsewhere, and then returned to you for treatment for complications.

Approximately how often do you have to do that?

A. They are—going all the way back to being a medical student at Cook County Hospital where they had a significant number of those even in the short period of time I was there.

But in practice, probably at least a couple of times. Two or three times a year. It is not uncommon, but it is not something we see every month.

Q. Doctor, have you consulted with other doctors at Evanston Northwestern Healthcare regarding the performance of abortions on live fetuses?

A. Yes, I have.

Q. Doctor, you also mentioned having studied the literature on abortion. And you mentioned several contexts in which you have done that.

First of all, the special AMA Committee on intact D&X, how did that service effect your familiarity with the methods of abortion?

A. It probably was the first time that I got as deeply involved, because that committee was appointed. And then, for [1020] several months reviewed the literature, had meetings, telephone conference calls, faxes. A significant amount of work went into preparing that task force report because it was a major report that was going to go before the entire House of Delegates. And so a significant literature research by a panel, by a staff, by other members of the committee, and, again, representatives of various counsels.

Q. Doctor, you also mentioned writing an article for JAMA. Is that the Journal of the American Medical Association?

A. Yes, it is.

Q. And can you tell us how you came to write that article?

A. Because of my involvement on the task force and involvement at the AMA House of Delegates and because the topic was so popular in the media at that time—things were going on at the national level. Actually, in Illinois, people were taking surveys.

What happened is that Dr. Grimes wrote a paper and sent it in to JAMA as supporting the continued need for the procedure the editors of JAMA wanted to use it. They have a controversy section where they have one article pro and one article con on an issue. And they thought this was such a prominent issue in the media, in the public at that time that this would be an ideal situation.

Because of my position on the task force, because of my activity at the AMA House of Delegates at the AMA. I was [1021] well-recognized in this area. They

had heard my presentations. And the editor of this portion of JAMA called me and said:

> "We have this one article. We need the article taking the position on the opposite side. And would you be willing to do this?

Recognizing it was a great deal of work to do this and would require a great deal of research, I did kind of think about it for awhile. And then, I did say I would be willing to do the work to prepare that article.

MR. SIMPSON: Your honor, I would like to show the witness Exhibit A-55. But we would like to make a substitution here, if we could.

I am aware that the copy of A-55 that is in the evidence binders is a copy of Dr. Sprang's article from the Congressional Record. But the print in that copy is very, very small.

With the court's permission, I would like to substitute a copy of a reprint of that article with more readable type.

THE COURT: I am sure that is fine.

You are right. I can't read that.

THE WITNESS: I looked at it. I couldn't read it, either.

MR. SIMPSON: Could I approach the witness, please, Your Honor?

[1022]

THE COURT: Yes, you may.

May I just discard this one?

MR. SIMPSON: Yes. That would be fine.

BY MR. SIMPSON:

Q. Doctor, I have shown you what is now Exhibit A-55 in this case. Do you recognize that document?

A. Yes, I do.

Q. What is that?

A. It is the article I wrote for JAMA in 1998.

Q. Doctor, could you—we are going to be talking in some detail about the content of the article. But could you at this point just kind of briefly describe it to us?

A. Basically, my emphasis—and really I had not been interested in the abortion issue before. But my only interest was really in the part, the intact D&X. And that's kind of what I wanted to write about.

Because the other article was more broad and included all of the later term abortions, they asked me to kind of try to include other things besides intact D&X. So I acquiesced, reluctantly.

So I actually kind of divided this article into the first portion, which specifically addressed intact D&X, and then I had to include a second portion. And there is a lot of overlap in the same complication rates and indications and when they do it. So, actually, it is broken into two parts. One: [1023] intact D&X, and then, in general, just abortions that are performed, I would say, late in the second-trimester. And by "Late in the second-trimester" I will probably say 20 to 27 weeks.

Q. Okay.

A. So it is divided that way.

Then, I kind of obviously needed to take some format, some way of setting it out. So I set it out as

kind of first defining, saying what brought this issue to the forefront, what was kind of going on in the media.

Then, I kind of used ACOG definitions and tried to use other definitions so everybody would know what we were talking about.

Then, I broke it into maternal considerations, fetal considerations, ethical considerations and what was going on in the various professional organizations, legislative and public. Because by this point 27 states had passed bans on intact D&X. And so there were all different areas.

So just to have a reasonable way of presenting information, I broke it into those areas. And then, I did the same thing for termination of late term pregnancies, in general, because that is what the editors wanted me to do.

Q. Thank you, Doctor.

Doctor, you mentioned doing research into—am I saying this correctly? Did you do research regarding abortion [1024] methods to write this article?

A. Correct.

Q. Research into the medical literature?

A. Correct.

Q. Doctor, does that article include discussion of the human fetuses' reaction to painful stimuli?

A. It does.

Q. So, have you done research into the medical literature on that topic, as well?

A. I have. Also in my formal training, I did spend time in anesthesia, which is obviously pain management

and spent some time there, as well. But specifically for this I looked for articles on fetal pain. I was looking at both the anatomic progression of when nerves go to different areas and how they progress up to the thalamus and the brain.

I looked at various studies that showed changes that had been done in different studies in ultrasound on blood flow and actually measuring hormones. And I will also say that I have been in nurseries with actually—was in a nursery in St. John's that had three or four babies that were delivered that were 23 weeks or 24 weeks.

And so then at that point they are babies, not fetuses, but during the same time frame that we are talking about, during the 23, 24 week time frame. And in the nursery at that level, you can see the response to pain. If the [1025] neonatologists are performing procedures, they give—they use anesthesia. And it is the same time frame we are talking about.

MS. GARTNER: Objection, Your Honor. I am not sure if he is giving testimony about fetal pain or not at this point. But he hasn't been qualified as an expert in any area yet, so I don't know in the context of trying to have him qualified, if he is actually getting into the area of giving testimony.

THE COURT: Let's let Mr. Simpson explain. You haven't moved to qualify him in any particular area. Is this one of the areas in which you are attempting to qualify him?

MR. SIMPSON: Yes, we are, Your Honor. And I was about to get to the point of asking him to be qualified.

But let's move on to the next topic, and then I will ask him to be qualified and state the subjects of that qualification.

THE COURT: Okay.

BY MR. SIMPSON:

Q. Doctor, you also mentioned having testified in court regarding abortion methods. Now, you mentioned this case, for one thing.

Have you testified in either of the other cases that are currently ongoing regarding intact D&X?

A. I have testified in Lincoln, Nebraska.

[1026]

Q. Were you qualified as an expert in that case?

A. Correct.

Q. Have you testified in the New York case?

A. I had—

MS. GARTNER: Objection, Your Honor. I am sorry, but I—and I apologize for objecting so much—but I believe that, in fact, in the Nebraska case, the court is not actually qualifying witnesses as experts, but is simply taking all of the experts that are presented, taking their testimony. And the court has indicated he will give the witnesses the weight that he thinks is appropriate.

But, in fact, nobody in that case has been proffered as an expert or qualified as an expert.

MR. SIMPSON: I was unaware of that, Your Honor.

THE COURT: Okay.

BY MR. SIMPSON:

Q. And, Doctor, will you be testifying in the New York case, as well?

A. Correct.

Q. I think you mentioned another case. You said "the Ohio case." Was that a case challenging the Ohio statute on what are called "partial-birth abortions"?

A. It was a case challenging an Ohio ban on intact D&X. And I was, to the best of my knowledge, was qualified as an expert in that case. And I did talk about both the medical aspects, the [1027] ethical aspects and fetal pain at some length.

Q. Doctor, was that Ohio case—

A. I was challenged by the plaintiff's bar, and the judge in that case did allow me to testify.

Q. Doctor, was that Ohio case Women's Professional Medical Corps versus Taft?

A. Correct.

Q. That was in the federal court in Ohio?

A. Correct.

Q. And did that experience affect the level of your familiarity with abortion methods?

A. Again, same reasons. Obviously, before you are involved in something like that, you research the literature.

And, again, you are given the opportunity to read declarations and depositions, which I just find actually reading a 200 or 300-page deposition in great detail on individuals who actually are performing them on a day-to-day basis gives you a great deal of insight

into exactly what they are doing, how they are doing it, and why they are doing it, because they are responding to very specific questions. So, yes.

MR. SIMPSON: Your honor, we would like to move to qualify Dr. Sprang as an expert in obstetrics and gynecology, including the methods used to remove the products of conception before term and their risks and complications, the ethical [1028] considerations that guide obstetrical practice and the reaction of the fetus to painful stimuli.

THE COURT: The second category?

MR. SIMPSON: The ethical considerations that guide obstetrical practice.

THE COURT: No, before that.

MR. SIMPSON: Just part of the first part, obstetrics and gynecology, including the methods used to remove the products of conception before term and their risks and complications.

THE COURT: All right. Is there any objection on those categories?

MS. GARTNER: Yes, Your Honor. We have obviously no objection to Dr. Sprang being qualified as an expert generally in the area of obstetrics and gynecology.

But, Your Honor, I would like to do some voir dire to see if we can define the scope of his testimony.

THE COURT: You may.

MS. GARTNER: Thank you.

[SPRANG—VOIR DIRE EXAMINATION]

BY MS. GARTNER:

Q. Good morning, Dr. Sprang.

A. Good morning.

Q. It is good to see you again. My name is Eve Gartner.

A. I know.

[1029]

Q. And we met at Evanston, right?

Dr. Sprang, you have done no clinical research in the area of abortion; is that right?

A. I am thinking because I am involved in helping the students do a lot of different things, as well. I don't believe I have actually been involved in a paper, though I do work with the students, and some of them are doing research on that.

Q. And you don't give formal, planned lectures on abortions to medical students or residents, do you?

A. I have. Yes and no. On the ethical aspects of it I have given presentations to residents and students on the ethics of, especially intact D&X.

Q. Have you ever given a formal, planned lecture on how abortions are performed to medical students or residents?

A. We had this discussion before. I have given presentations at luncheon meetings which are scheduled. I won't say how formal they are. But we have discussed this with the residents at luncheon meetings. And the question is, obviously: is that formal or not?

MS. GARTNER: Your Honor, may I hand the witness his deposition?

THE COURT: Yes.

MS. GARTNER: I will hand you one, as well.

BY MS. GARTNER:

Q. Dr. Sprang, I am hand handing you the deposition that was [1030] taken of you in this case in February. If you could turn to page 47 of the deposition.

And if you could look at the answer that you gave on lines 22 to 24 of your deposition.

And let me ask you, again: do you give formal, planned lectures on abortion to the medical students or the residents?

A. I will answer directly. What I said was:

"I do not give formal, planned lectures."

The distinction I am making is these lecture are not always that formal, but they are luncheon lectures. So, yes. But specifically if you are asking me formal, no. Okay?

Q. Okay.

A. It is a distinction, but it is real.

Q. Okay. And other than the piece that you were just talking about that was published in the Journal of the American Medical Association, JAMA, you have not published in the area of abortion; is that right?

A. Yes and no, because when you publish something like this there are then letters to the editor. And then you do response to that. So I have had other published responses to the letter to the editor in JAMA. I have given presentations on the ethics in the general area of intact D&X at bioethics seminars.

Q. Okay. What I specifically—

A. It is published.

Q. Okay.

[1031]

A. That is where I'm going with it. So it is published.

Q. Okay. So you have, after this article was published in JAMA, there was some letters to the editor responding, and then you replied to those letters?

A. Correct.

Q. Is that correct?

A. And in the bioethics seminar in Indiana they then publish the comments from that presentation in their hospital-wide magazines or journals.

Q. Okay. So that was published in a hospital magazine? It wasn't a peer-reviewed journal?

A. Correct.

Q. Okay. And this, the article that was published in JAMA—is it okay if I call it "the Journal of the American Association," JAMA?

A. Yes, certainly.

Q. Okay. So that was an opinion piece, correct?

A. I would not say that. It is definitely a peer-reviewed journal article. It was not an opinion. It was scientifically based. And when they—actually, the first draft, which is often the case, I said:

> "I probably should get more opinions."

And they said:

> "No. We want more scientific literature and more backing and more factual information."

[1032]

So that I actually had to then take another month or two and redraft it and pick at least another 10 journal articles which substantiated the comments I made in that article.

So I would not call it "an opinion piece."

Q. Okay. But isn't it correct as you testified just a few minutes ago, that the way this came about is that Dr. David Grimes had drafted an opinion piece for JAMA, opposing restrictions on later abortion methods, and the journal was looking for somebody to write a piece taking the opposite position to publish with Dr. Grimes?

And weren't they, in fact, published in a section of JAMA called "Controversies"?

A. Correct. But, I will not agree with you that it is an opinion piece. It is a scientific piece based on the scientific literature.

Q. There were competing pieces taking opposite viewpoints on this; is that correct?

A. Correct.

Q. Okay. Now, you had testified earlier in response to Judge Hamilton's questions about the numbers of abortions you've performed at the gestational—the number of abortions you've performed and the methods you've used, correct?

A. Correct.

Q. Now, you have not performed—even in the case of a [1033] demised fetus, you have not done an abortion using the D&E method after approximately 17 weeks of pregnancy; is that right?

A. That is correct.

Q. And that's because you believe that a physician must have significant expertise to do a D&E after that time period; is that correct?

A. I believe there is more risk involved unless you really do them on a daily basis, correct.

Q. But you would believe a physician must have significant expertise to do a D&E after 18 weeks, right?

A. Significant experience and expertise, correct.

Q. And you have many areas of expertise; isn't that right, Dr. Sprang?

A. Right.

Q. But doing post-18 week D&E's is not one of your areas of expertise, is it?

A. I will have to say: correct.

Q. Dr. Sprang, do you plan to offer testimony today about the safety of a method of abortion called "intact D&X" or "intact D&E"?

A. Based on my literature review and talking to physicians who perform them, yes.

Q. Now, it is your understanding, right, that this method of abortion is used primarily after 18 weeks of pregnancy?

[1034]

A. After specifically—and, again, a good deal of research and Haskell's report, which he presented to the National Abortions Federation in '92 says this is primarily used between 20 and 26 weeks.

Q. And that's a time period in which you have not done a D&E, correct?

A. Correct.

Q. And you have never performed an intact D&E procedure; is that correct?

A. There in—actually, in 16, 17 weeks I have on a dead fetus who also—she had started to go into labor herself. And I would say, essentially, it was an intact D&X.

Q. But you just testified that in your understanding is that intact D&E is used after 19 weeks of pregnancy.

A. Primarily.

Q. Okay. So, you—and in that intact D&E procedure that you did, how was the—can you describe how the procedure went?

A. Fortunately, as I said, it was a fetus had already been dead. We actually scheduled her for surgery. And just between like scheduling it and actually bringing her to the operating room, the cervix had started to dilate. And at that point she was partially doing it spontaneously.

The fetus was still inside. And it was very—at that point very easy to just extract the fetus.

Q. So, when you said you did an intact D&E, you basically used [1035] traction to pull the fetus out of the uterus?

A. That's my understanding of an intact D&X.

Q. You didn't have to do anything to reduce the size of the fetal head?

A. Because of the softness of the fetus and the amount of dilatation, that is correct.

Q. Okay. And you—so that's a different—that is not really a D&E procedure in the way that you under—I am sorry.

That is not really an intact D&E the way you understand, based on your literature review; is that correct?

A. It's not totally consistent with the definition that they usually have to do something else to the cranium, the fetal skull at the—

Q. And you have never done that, right? You have never had to do anything to the fetal skull to complete the delivery?

A. May I finish the first—

Q. Sure. I am sorry.

A. Well, repeatedly, in looking at those declarations —and it is more information for me now—oftentimes they don't have to do anything, either. The fetal skull actually just delivers.

And actually in one of the expert depositions they actually say that is their preference. That the cervix is dilated enough that they can just simply deliver the fetus the same way I would do it for breech extraction. And I have done [1036] a hundred of those. You don't need—if it is dilated enough, you don't need to do anything to the skull. You maneuver called the mauriceau-smellie-viet—they never spell it correctly—try to flex the fetal head to make it a smaller diameter. You can actually, if the cervix is dilated enough, deliver it.

Q. And you have—

A. And that is what is being done in this procedure because I've seen several of the declarations in depositions that say that. And actually one of the experts actually says that is the ideal situation.

Q. And when you—

A. So they are—

Q. —Say you've done a total breech extraction a hundred times, you are speaking about at term to deliver a live baby, right?

A. Here, again, not necessarily at term, because definition of "at term" would be beyond 37 weeks. And people go into premature labor at 32 weeks, at 34 weeks. Twins more commonly go into premature labor in that time frame.

So I have done total breech extractions various times frames, which can all be considered to be premature. And, again, I have been doing this long enough before some of the current thinking that that is not all we do now. We would do a cesarean section. But at that point in time we did [1037] extractions.

I had a set of twins that I did a—

Q. I am sorry, Dr. Sprang. I am just afraid we are never going to get—

MR. SIMPSON: I'm sorry, Your Honor. I need to object to Ms. Gartner interrupting the witness. It has happened—

THE COURT: I am not sure he is responsive to her questions. She is trying to qualify him.

THE WITNESS: You have to—

THE COURT: I think I'm going to ask you just to answer the questions as directly as you can.

THE WITNESS: Yes, ma'am.

THE COURT: You, obviously, will get another chance to talk.

THE WITNESS: Okay.

BY MS. GARTNER:

Q. Yes. And I don't mean to cut you off. I just—I think—I don't want you to have to go to the effort to keep talking about something that is not really that relevant here.

And my question really—I might have misspoken in saying "at term."

But let me just ask you: the breech extractions you've done have been to deliver a live baby; is that correct?

A. Correct.

[1038]

Q. Thank you.

Now, you have never witnessed an intact D&E abortion being performed, have you?

A. Correct.

Q. And from listening to your testimony this morning, from obviously being present at your deposition earlier in this case, and from reading the transcript of your testimony in the Nebraska case earlier this week, I've identified what I think are six bases for your familiarity with the intact D&E abortions.

And I have tried to be as liberal in my understanding of your testimony as possible. And I would like to list for you what I understand to be the bases for your testimony about intact D&E.

And if you could just tell me whether I am correct about that, that that is, in fact, part of the basis for your testimony. And then, I would like to go through them in a little more detail, if that is okay with you.

So my understanding is from your deposition you said that part of your familiarity with this procedure is based on a conversation with the physician who was the President of ACOG at the time that ACOG issued its statement of policy regarding what it calls "intact D&X" in 1997? Is that part of the basis?

A. No.

Q. Okay. That's good.

[1039]

Now, the other thing I identified is that you—part of your basis is from the work you did on the AMA task force that you were discussing with Mr. Simpson; is that correct?

A. Correct.

Q. Now, I think Mr. Simpson had referred to that as a task force on intact D&X. But it wasn't, in fact, a task force on intact D&X, was it?

A. I would say: Yes.

Q. Was it not a task force more generally on late term pregnancy termination techniques?

A. The reason the task force was set up was to look at intact D&X. That was the resolution that caused the task force to be set up.

Q. Did the task force prepare a report on its work?

A. Yes. It looked at more broad information as a basis trying to get the complication rates, the number of procedures. But the reason for the task force being set up is intact D&X.

Q. Okay. And in addition, an additional basis for your testimony is conversations you've had with a few physicians who perform intact D&X; is that correct?

A. Correct.

Q. Okay. And an additional basis is a paper that was presented by Dr. Martin Haskell to the National Abortion Federation in 1992; is that correct?

[1040]

A. Correct.

Q. And another basis is the declaration and depositions of physicians in both the federal court case in Ohio where you testified and other physicians who have testified in this case; is that correct?

A. Correct.

Q. And I think you also mentioned this morning an additional basis is the opinion piece you did or the piece you did—I am sorry—for JAMA?

A. Correct.

Q. Is there anything I have omitted from this list in trying to identify the bases for your testimony?

A. I think other articles are out there, as well, in general. And I started talking about D&E. And obviously the most recent article—in the declaration of Chasen the most recent article that was introduced on his article on trying to compare the traditional D&E and intact D&X.

Q. Okay. So let's go back through some of these bases in just a little bit more detail. The AMA task force, I think you testified that there were 10 physicians on that task force; is that correct?

A. Correct.

Q. Ten including yourself?

A. Correct.

Q. Okay. Now, were any of the physicians on the task force [1041] physicians who perform intact D&E?

A. I don't know that for a fact. I do know that at least four of them are obstetrician gynecologists. I believe that is correct.

Q. During the meetings of the task force did any of the obstetrician ever indicate they performed an intact D&E?

A. Not to my recollection.

Q. Now, did—in preparing that report, did the task force meet with any physicians who performed intact D&E's?

A. I don't believe we met with any. Whether did they interview? Was there information from interviews with physicians who performed them? I am not a hundred percent sure.

MR. SIMPSON: Your Honor, I don't know how many more questions there are on the AMA task force, but I believe we are getting beyond voir dire here and into discovery regarding the AMA task force.

MS. GARTNER: Well, your honor, I think if the participation in the AMA task force is a significant part of the basis for his opinion, I think we need to understand whether the task force, in fact, did an investi-

gation that would validly lead to his having firsthand knowledge about these procedures.

THE COURT: I will allow you to go further.

MS. GARTNER: Thank you.

[1042]

BY MS. GARTNER:

Q. Did the task force speak directly with any physicians who perform intact D&E's?

A. Did I personally? No. Do I believe representatives from ACOG, from other councils? I do believe they did, because they talk more specifically about it, so yes.

Q. But did anyone on the task force speak with physicians who perform intact D&E's?

A. Yes, I believe they did.

Q. Okay. But you did not?

A. I did not.

Q. And did anyone—

A. I had spoken with people prior to that who did do intact D&X.

Q. Let's talk about that. With respect to those physicians that you have spoken to that perform what you are calling intact D&X, am I right that there is only two incidents where you can actually remember talking to an individual who performs intact D&X, right?

A. Yes and no. There were two that I spent a significant more time with that were more memorable discussions because I talked to them after the meetings, as well, and got more information.

There were several —and I believe I said this in my deposition. When I am putting on programs and putting on high risk fetal medicine programs, often a case example would [1043] be a patient comes in at 23 weeks with a ruptured bag of waters. What are the different ways of handling that situation?

You are talking about a fetus at that point that has maybe a 15 percent viability at 23 weeks. If you can carry it a little further you would have greater viability: 50 to 75 percent.

So you get different opinions from different maternal fetal medicine physicians as to some would try to wait and carry it a little further.

So in discussions of those you get different opinions from physicians in the audience who are from all over the United States. And some of them might have more aggressive roles, aggressive positions, because they are more familiar with doing these D&X's than, say, the way they would handle it than just terminate the pregnancy and then let the patient get pregnant again.

The majority of physicians in those situations would say if there is not a fever, admit the patient to the hospital, keep them at bed rest for a couple of weeks and try to get it further along.

So you are talking about these procedures. And you are talking about it with physicians who are giving their opinion of how they would handle that situation. And one of the ways is to do a D&E or intact D&X.

[1044]

Q. Now, let's talk specifically about what you refer to as the two memorable occasions in which you've spoken with physicians about intact D&X.

With respect to those two individuals, you actually can't recall the names or locations or dates involved with any of those conversations, correct?

A. Correct. As I said, if you are giving three to five programs a year to hundreds and ultimately thousands of physicians, it is very hard to remember even what city it was in.

Q. Right. So these were the memorable conversations about intact D&X, but you don't remember who the physicians were?

A. The information was memorable. That is what I was looking for was trying to acquire information.

Q. Now, let's talk about Dr. Haskell's presentation in 1992 to the National Abortion Federation.

Were you present when he made his presentation?

A. I was not.

Q. Have you ever met Dr. Haskell?

A. I may have seen him in Ohio. I don't recall, because he was—in the Ohio case he was actually one of the plaintiffs.

Q. Have you ever spoken with Dr. Haskell?

A. I could have, because I spoke—I could have. I could have said "hello" in the courtroom. I don't remember.

Q. Okay. But if you spoke to him it was just to say "hello"?

[1045]

A. Yes.

Q. Do you have any firsthand knowledge of whether Dr. Haskell still performs abortions today in the way he described in his paper in 1992?

A. I know what he was doing at that point in time. Do I know exactly what he is doing at this point in time? I do not.

Q. Okay. Now, with respect to the declarations and depositions in the Ohio case and this case, this is—you've read the declarations and depositions, correct?

A. Correct.

Q. Have you met the people whose declarations and depositions you've read other than maybe to say "hello" to them in the courtroom?

A. I know some of them personally, yes.

Q. Okay. Do you have any firsthand knowledge about how they perform abortions other than reading their depositions and declarations?

A. To some extent, yes, because some of them are in my institution and I do know what the residents say about what is going on. So to some extent yes.

Q. So you are referring specifically to Dr. Hammond and Dr. Frederiksen?

A. Yes, correct.

Q. Other than Dr. Hammond and Dr. Frederiksen, you don't have any firsthand knowledge of how they do abortions; is that [1046] right?

A. How they—correct.

Q. And with respect to Dr. Hammond and Dr. Frederiksen what you know about how they do abortions is from residents in your institution?

A. Correct.

Q. And then, now turning to the issue about fetal pain, you are not an expert on fetal pain, are you?

A. Only insofar as I did take as—part of my training and residency was in anesthesia. Again, in writing the papers, I reviewed literature, reviewed a number of articles on the anatomic progression of the nerve supply in the fetus. And I understand that. I understand the growth of the nerves to the skin and where the nerves are going to the thalamus and then they reach the subcortex.

I have been involved to that extent.

Q. But you are not a neurologist, are you?

A. I am not a neurologist.

Q. And you are not an anesthesiologist?

A. I did have training in anesthesia.

Q. You have done no clinical research yourself in the area of fetal pain, have you?

A. The clinical research I've done is when I am doing an amniocentesis at 16 weeks and poke the baby with the needle and the baby's arm retracts.

[1047]

Q. You testified in your deposition, Dr. Sprang, that part of the basis for your opinions about fetal pain is the testimony that was given in the Ohio case by an anesthesiologist; is that correct?

A. I did read the deposition of the anesthesiologist, and I believe from Vanderbilt where they are actually doing intrauterine surgery at 20, 21, 22 weeks. And they, I believe as you know in those cases actually open up the abdomen—

Q. My question, doctor—

A. They have the fetus in front of them.

Q. I am not asking you what he testified. I am asking you whether reading that deposition is part of the basis for your testimony about fetal pain?

A. Correct.

Q. But you don't remember exactly who that anesthesiologist was or where he worked, do you?

A. I could easily get that information.

Q. But you don't recall, do you?

A. No.

MS. GARTNER: Your Honor, as I said, we agree Dr. Sprang is an expert in obstetrics and gynecology, but we don't believe that he meets the requirements under rule 702 or 703 to offer opinions regarding the safety of intact D&E or fetal pain. Rule 702 requires that expert testimony be based on sufficient facts or data.

[1048]

And while a physician may be an expert in his or her specialty area, as Dr. Sprang clearly is, that physician can only offer expert testimony where he bases his opinion upon specialized knowledge or experience on the particular subject.

And Dr. Sprang has no specialized knowledge regarding intact D&E procedures.

Essentially, Dr. Sprang bases his opinion on conversations with other medical professionals, on a presentation given by Dr. Haskell, on declarations and depositions of experts in this case and in another case. And these sources are all hearsay.

And while Dr. Sprang is permitted to base his opinion testimony on hearsay, he can't simply summarize these sources for the court and essentially serve as nothing but a conduit for the hearsay evidence, without adding anything to it.

And we would submit that that is really what would happen if Dr. Sprang testified about intact D&E: He would be a conduit for reporting to the court about other people's experiences, which he understands simply from reading about them.

And, in addition, because Dr. Sprang can't remember the names, he bases his testimony, in part, on conversations with two physicians, but he can't remember their names.

So there was no way for plaintiffs to attempt to [1049] verify whether these were reliable sources or not or attempt to contact those physicians to find out exactly what they understood their conversations to have been about.

So for those reasons we would ask the court to restrict Dr. Sprang's testimony about abortion practice and safety to those abortion methods that he has actually performed at the gestational ages that he has performed them.

And in addition we would ask the court to find that Dr. Sprang is not an expert in fetal pain. I understand that the government has another expert directly relating to fetal pain. He will be testifying next week.

Dr. Sprang is not an expert in fetal pain, and we believe he should not be permitted to testify on that subject.

THE COURT: Thank you.

Mr. Simpson, your response?

MR. SIMPSON: Your Honor, could I ask a few follow-up questions to the witness and make some argument, please?

[M. LEROY SPRANG, M.D.—CONTINUING DIRECT EXAMINATION]

BY MR. SIMPSON:

Q. Dr. Sprang, Ms. Gartner asked you about reading Dr. Haskell's presentation. Have you read any other presentations on intact D&X?

A. I have, and various articles, and, again, in declarations and depositions.

[1050]

Q. Have you read a presentation by Dr. McMahon on intact D&X?

A. I have.

Q. Doctor, earlier you testified as serving as the chairman of the board and president of the Illinois State Medical Society. Has that service affected your familiarity with abortion methods?

A. It has, again, because of the case reviews and because of reviewing quality assurance things at that level, you are presented cases like that.

Q. Doctor, have you been—at least at times—the only obstetrician gynecologist on the board of the Illinois State Medical Society?

A. Most of the time I am the only obstetrician gynecologist on the board. And, similarly, with the liability insurance carriers as chairman of the board, and being the only OB/GYNE most of those cases have always been presented to me.

Q. So how has your being the only obstetrician gynecologist in those contexts affected your familiarity with abortion methods?

A. Any of the cases that resolve around that area are brought to me.

MR. SIMPSON: Your honor, Dr. Sprang obviously has a vast experience and background in obstetrics and gynecology, in general. He has, besides that, that general experience and knowledge of female anatomy and how things work and in providing treatment in those contexts.

[1051]

He has, as he has testified, removed the products of conception himself many times and has treated complications of abortions a number of times.

He has done an extensive study on abortion methods, including intact D&X. He has testified in two other cases relating to intact D&X. And he has read many materials from physicians in connection with those cases.

He has spoken—as we have heard, he has spoken to physicians who perform this procedure. And I should point out in that regard, Your Honor, the way in which doctors typically gain much of their knowledge is by discussing with other physicians and learning in that way.

He does perform induction abortions after 16, 17, 18 weeks. And, Your Honor, I would point out that under 702, a witness—it says:

> "A witness may be qualified as an expert by knowledge, skill, experience, training or education."

I think plaintiffs' argument amounts to saying that a witness has to have all of those aspects of expertise. But, obviously, Dr. Sprang has—even if we are only limiting it to intact D&X, he has the knowledge, even if he doesn't have the experience in performing that precise procedure.

I should say finally, too, Your Honor, plaintiffs' counsel's argument would appear to amount to an argument that [1052] defendant in this case can only call physicians who have performed intact D&X.

And I'm sure the court can appreciate the difficulty of finding a physician who has performed intact D&X who would testify that it is medically unnecessary and unsafe.

THE COURT: Okay. All right. You all have been fully heard on the qualifications of this doctor.

MR. SIMPSON: Yes, your honor.

THE COURT: I have some concerns. I don't doubt that Dr. Sprang is a very well-qualified and experienced obstetrician and gynecologist.

My problem, Mr. Simpson, is not that he doesn't have any hands-on experience performing D&X. I appreciate the difficulty that that were the case. He doesn't appear to have any personal experience with late term abortion procedures that are at issue here.

He has testified that he has only performed procedures on 6 to 17-week fetuses. He has not only himself never performed an intact procedure, aside from the one hysterotomy, but he has never observed the performance of that procedure.

It would seem to me that if I were to accept him as an expert on intact D&X, that that would necessarily mean that anyone who is an OB/GYN would be able to review articles, talk to other physicians, and thereby be an expert.

[1053]

I kind of think 702 requires a little bit more than that. So, I am not going to qualify him as an expert in the subject of intact D&X. Therefore, he may not give an opinion thereon.

With regard to fetal pain, I don't believe that his experience as an anesthesiologist or his training in anesthesiology is in and of itself enough to qualify him as an expert in that regard, particularly when I compare his background and training and experience with that of the expert that you proffered on that subject, who I have approved, at least tentatively, to testify on that area.

But the doctor certainly can testify as a percipient witness on the question of fetal pain. He can certainly testify as to what he himself has observed. But he cannot testify as an expert in offering an opinion on fetal pain.

So with that said, he may testify as only a percipient witness on those two areas, and not on an expert. You offered him as an expert on the question of the methods of removal of products of conception.

To the extent that that includes intact D&X, he may not testify on that limited area. But he may testify on the other areas, because he does have experience on the other methods of removal of products of conception.

MR. SIMPSON: Your Honor, obviously the core issues here are the safety of intact D&X and its relative safety in [1054] relation to dismemberment D&X and induction, and also secondly the medical necessity, or lack thereof, for using the intact D&X procedure in any particular medical circumstances.

Your Honor, if I can ask this. Your Honor, does the court's ruling mean that the court is going to preclude us from asking Dr. Sprang regarding his expert opinion on the medical necessity, if any, of intact D&X and the relative safety of intact D&X versus other procedures?

THE COURT: Well, my thoughts were primarily with regard to the actual technique itself. I wasn't focusing so much on the safety of that technique. But you all can address that before I make a final determination as to what that limitation entails.

Are you offering a proof of some kind that he does have expert testimony that is not affected by his lack of experience in D&X that might be pertinent on the question of the medical safety aspect of it?

MR. SIMPSON: Absolutely.

THE COURT: What is that?

MR. SIMPSON: Well, Your Honor, based on his broad knowledge of obstetrics and gynecology in general, and his broad knowledge from many different sources as to how intact D&X is performed, we believe that he can give an expert opinion as to whether that procedure is safe, safer, less safe than other abortion methods, and regarding whether that procedure [1055] needs to be used in any particular medical context.

THE COURT: All right. Response?

What I am trying to figure out is there a way to parse this so he could—obviously, the defense wants his testimony on various different subjects. I have ruled that with regard to the techniques involved he has no expertise.

However, there is the question of whether or not, notwithstanding his personal experience and expertise in performing it, whether or not there is still room for him to give his own legitimate opinion. Indeed, I guess could any OB/GYN opine on the safety of it.

It would seem to me that most practitioners do form opinions about the safety based of procedures upon the kind of activity that Dr. Sprang is engaged in, and that is by reviewing reports and that kind of thing.

MR. SIMPSON: If I can make two other points, please, Your Honor.

As I think I mentioned earlier, if the court is going to preclude us from asking Dr. Sprang about those two core areas, because he has not done intact D&X procedure, that—

THE COURT: It is not because he has not done the procedure. I do not require that in order for a

witness to be qualified to give that kind of opinion that he actually have performed it, but he actually has to have some personal [1056] knowledge. It is not just a matter of talking to others and making a decision about the actual procedure.

Safety of a procedure is a little bit different, though, because I would imagine most doctors give their experience in being able to determine whether or not something is safe from reading and talking to others. That's a little bit different.

There is testimony here about the actual technique and how it is performed, et cetera. That's separate and apart from whether or not that technique is safe.

MS. GARTNER: Your Honor, I think we would have no problem with the way that Your Honor has articulated it. But our concern was that Dr. Sprang isn't in a position to describe for the court how this technique is done because he has not done it or witnessed it.

But we don't have a problem with him as an obstetrician gynecologist testifying about his opinion of the safety. And your honor can judge how weighty that opinion is given he has no experience with it.

THE COURT: Certainly.

MS. GARTNER: Thank you.

THE COURT: Then, I think that that's how I will resolve the issue. He will not be qualified to testify about how the technique is performed, but to the extent that he has a view about how it is performed based upon what he has read, he [1057] may give an opinion

about how safe that is relative to the other procedures that we have been discussing here.

MR. SIMPSON: Thank you, Your Honor.

THE COURT: We are going to take a break, and then maybe you can reformulate your questioning. I'm sure the ruling will have some effect on how you want to approach your examination.

We will break for 15 minutes.

(Recess taken at 10:00 A.M.)

(Proceedings resumed at 10:15 A.M.)

THE COURT: Okay. Now, just to make sure that before you get started that we all understand the parameters, I made the finding that the doctor doesn't have sufficient personal experience to qualify him as an expert in how D&X or intact D&E's performed.

That is based not only upon the fact that he hasn't performed the procedure, but also that he hasn't supervised anybody else performing it. He hasn't observed it being performed by anybody else. He has not been taught the procedure, nor has he himself taught the procedure to someone else.

The witness may opine, however, on the safety of the procedure based upon his understanding of what the procedure entails and based upon his independent study and review of the procedure. He may offer an opinion on how safe it is or unsafe * * *.

* * * * *

[1079]

Q. Doctor, do you have an opinion as to whether the intact D&X procedure presents significant risks to the woman?

A. I do.

Q. What is that opinion?

A. I do present—I have the opinion that it presents serious safety risk to the mother.

Q. Do you have an opinion or opinions as to what those risks are, yes or no?

A. I do.

Q. Could you just at this point, doctor, list those risks for us, in your opinion? Just list them at this point, and we will ask specific questions about them.

Q. The risk of the serial dilation in the cervix, the extent to which the cervix is dilated, the risk of infection from the laminaria, the risk of trauma from doing an internal podalic version, the risk of trauma from using a sharp instrument, mainly scissors, in doing this procedure.

Q. Doctor, first of all, let's go through each of those. You mentioned the risk of the dilation of the cervix.

Can you describe for us why you—why it is your opinion that dilation of the cervix for intact D&X presents risk to the woman?

A. In each of the steps we talked—in each of the steps we spoke of, by first mechanically dilating it from 10 to 11 millimeters, which is what he says he does, that is a [1080] certain amount of cervical mechanical dilation and trauma.

Placing laminaria in, both a certain amount of trauma from the laminaria, and then from the dilation with laminaria, the potential for trauma to the cervix.

Again, placing 20, 25, 30 laminaria in the second day, again, the amount of dilatation is much greater,

and therefore numerous articles in the past have said the amount of cervical dilatation does have the potential for damaging the cervix and the potential for either leading to incompetence or premature labor and delivery in subsequent pregnancies.

Q. Doctor, you mentioned cervical incompetence. Can you kind of describe to us what that is?

A. What happens in various procedures is in the process of dilating the cervix, some actual trauma is done to the tissue of the cervix so that in a subsequent pregnancy as the uterus and the pregnancy progresses, typically at about 14, 15, 16 weeks, because the cervix is weaker, the amount of pressure in the uterus causes it to just passively dilate, and thereby losing that pregnancy.

Q. Doctor, you also mentioned premature labor. Can you describe to us what that is?

A. If you—again, if you damage the cervix, then even if it doesn't cause an incompetent cervix in loss mid-trimester, it, as the pregnancy progresses, the intrauterine contents clearly are increasing in size and mass and weight, and the cervix [1081] which normally may be able to go to 40 weeks, may, because of its weakness, start going into labor or have contractions at anything that I will call premature labor, at anywhere from 27, 28 weeks on to 37 weeks, which is the definition of premature labor and delivery.

Q. Thank you, Doctor.

I would like to read a couple of sentences to you from your JAMA article. Do you still have that in front of you, Exhibit A-55?

A. I do.

Q. I would like to read a couple of sentences from that and ask you a few questions about them. On the third page there is a heading toward the top of the page that says:

"Termination of Late Term Pregnancies."

Do you see that?

A. Yes.

Q. I am going to read at the bottom of that left-hand column. There's a sentence that starts:

"Dilation and evacuation procedures."

Do you see that?

A. Correct.

Q. "Dilation and evacuation procedures commonly used in induced midtrimester abortion may lead to cervical incompetence, which predisposes to an increased risk of subsequent spontaneous abortion, especially in [1082] the midtrimester. Cervical incompetence is more prevalent after midtrimester termination of pregnancy than first trimester termination because the cervix is dilated to a much greater degree."

Are those your words, doctor?

A. Correct. And I gave the references in there. That is the low—the numbers after that are the articles that would substantiate what I said.

Q. And is that your testimony today?

A. That is my testimony today.

Q. Doctor, just to make one thing clear that excerpt uses the term "midtrimester." Does that simply mean the same thing as second-trimester?

A. Correct.

Q. Doctor, if an abortion were to cause cervical incompetence or pre-term labor, would the existence of that condition be discovered at the time of the abortion?

A. No, it would not.

Q. Let's see. You also mentioned infection as a potential risk of intact D&X. Before I ask you about that, could I ask you, doctor, what expertise you have in any—if any, regarding obstetric and gynecological infection?

A. Obstetric and gynecological infection has been a special interest and expertise of mine for approximately 20 years. I have been giving presentations as an invited speaker for about * * *.

* * * * *

[1085]

And I know that happens just obviously intuitively it happens, but the different authors, including Haskell, describes it in his paper that sometimes it breaks and sometimes it doesn't. And the next day when they remove them and proceed to the next step of the procedure, if it has—his comment is "if it hasn't already ruptured," which obviously tells you sometimes it does, then he ruptures the membranes.

So you have another significant risk of infection there, especially if it broke. You inserted them on day two, and you waited to day three to do the procedure, you've got a ruptured bag of waters with foreign bodies sitting in the cervix for potentially 24 hours.

Q. Doctor, you said something a few minutes ago about the amount of bacteria in the vagina. What I think you said was:

"10 to the ninth"?

A. Yes. It is a mathematical term. And you add 10, and add nine zeros. That is the number.

Q. Doctor, I think you also mentioned the internal podalic version as presenting a risk to the patient. Why is it your opinion that that maneuver presents a risk to the patient?

A. Having done it as well, there is a strong mechanical force in taking the fetus and basically forcing it to do a summersault within the uterine cavity. These are not little things that you just kind of push gently, and it just turns. It doesn't work that way.

[1086]

You are using a great deal of force in turning it upside-down that does trauma to the uterine cavity and could disrupt the placenta and cause bleeding. And rarely things like amniotic fluid embolus. Those are not common things that could happen, but rarely they could. And, in fact, in Williams' textbook of obstetrics, which is one of the most premiere, respected obstetrical textbooks for teaching medical students, when I was a student was the primary textbook, it specifically says that there are very few, if any, indications to do internal podalic version other than the second twin.

And in various editions he actually says it is potentially harmful. He says that it is the most common cause of traumatic uterine rupture.

Q. Doctor, if I can ask a few follow-up questions on those things. You mentioned disrupting—the potential for disrupting the placenta. What can that lead to?

A. Again, these are rare situations, but there is potential trauma if you disrupt the placenta at that point. There will be bleeding. And you are also—you have got vernix parts, white stuff on the fetus. There is not as much that early in pregnancy.

You have still got some amniotic fluid around. When you disrupt the placenta, some of that material can get into the maternal circulation, which could cause an amniotic fluid embolism in the mother, which is a very serious situation.

[1087]

Q. Is there any risk in that internal podalic version of causing maternal bleeding?

A. Because if you do separate the placenta, all the blood supply to the uterus goes to the surface of the placenta and stops there. If the placenta starts to separate, you, in fact, have an abruption of a placenta, and there would be internal hemorrhage.

Q. Abruption of the placenta, is that complete separation?

A. It could be a partial or a total abruption. And a portion can be separated and a remaining portion still attached.

Q. Doctor, would the degree of risk—you've testified to the fact that you have done the internal podalic version. And I assume you mean in delivering babies?

A. Correct. In similar time frames, because if you are doing an intact D&X at 23 or 24 weeks, when we

have twins they could go into labor at 28 weeks. They are very close in proximity to size. And if—I have done internal podalic versions.

I have actually delivered both of them breech. I actually delivered the first baby with internal podalic version, and then did a breech delivery. And then went in and grabbed the second baby and did a breech extraction of the second baby.

So, yes, I have done that.

Q. Doctor, you quoted a couple of sentences from Williams' Obstetrics, the textbook that you mentioned?

* * * * *

[1090] patient from piercing the back of the fetal skull in an intact D&X. Why do you believe that presents a risk to the mother?

A. Again, specifically using Haskell's description in his paper, what he—as he describes in detail, is if the head is trapped at the cervix, what he does is try to hold—puts some traction on the feet, put two fingers on the shoulders to lift the cervix so it is out of the way so it is less likely to get traumatized.

With the other hand —and my impression would be it is more blindly. I am sure sometimes it is low enough that you can actually see it. If you can get enough traction and bring it down low enough, but his description is that by feel you follow the spinal cord up the center to the base of the skull.

And then by feel, you are jabbing. No. "Jabbing" is not a good word. You are pushing the scissors through the fetal skull.

If you stay directly at the midline, that is a relatively avascular area. It should be relatively safe. But when you can't see that well what you are doing, and you are forcing them in on the fetal skull, it is certainly not inconceivable that because the skull—part of it is bone—it can slide a little to the left or to the right.

And if that happens to be the location where the uterine arteries come into the cervix, and if you were unfortunate enough to actually go sideways in either direction, [1091] could have significant hemorrhage in that situation.

Q. You said "significant hemorrhage," and you mentioned the uterine artery. Do you think there is a potential for actually piercing the uterine artery?

A. I do believe that potential is there. You have got scissors. You have got close proximity. And you are forcibly pushing the scissors through the skull. If you hit a soft spot, that should be easy. If you happen to get a firm spot, the scissors could just as easily slide one direction or the other.

And a pregnant uterus at term gets a pint of blood a minute going to it. So it is less than that at 23 or 24 weeks, but a very significant amount of blood supply.

Q. Thank you, doctor.

Do you have an understanding—you may have mentioned this earlier—do you have an understanding as to the gestational age at which intact D&X is usually used?

A. Again, specifically, it is stated in Haskell's presentation. And he says this procedure is often used in

the twenty—in fact, he says it is convenient to use in the 20 to 26 week time frame.

Q. Now, I believe you said earlier, Doctor, that disarticulation of the fetus in a D&E would become quite difficult, I believe you said, after 20 weeks?

A. It becomes more and more difficult with each passing week * * *.

* * * * *

[1105]

Q. Does this paragraph mean that serious complications are more likely with D&E than with D&X?

A. You can't come to that conclusion statistically in any way or I am sure they would have presented that. These complications are so uncommon you would probably need thousands of patients in both arms to see if there are any statistically significant difference. These are things that are just, I would say, a fluke.

The disseminated intravascular coagulation was, as they pointed out, was in a dead fetus, and if there was—

THE COURT REPORTER: I'm sorry—

THE WITNESS: —and it would be related to that, and not related to the procedure. And I think in this paper they in no way brought up that they continually thought the difference in the procedure was the cause of these.

So it is just the study does not have anywhere near enough numbers to look at things that are this rare to say there is no meaningful difference.

BY MR. SIMPSON:

Q. The next paragraph on page 8, which is the second full paragraph on the page, if I could read the first part of that:

> "45 women (17.1 percent) in the dilation and evacuation group and 17 women (15.0 percent) in the intact dilation and evacuation (sic) group had a subsequent pregnancy and receive care in our medical [1106] center. There were no second-trimester spontaneous abortions in either group. Spontaneous pre-term birth"—if I could stop there for a moment,

Doctor, can you explain to us the difference between spontaneous abortion and spontaneous pre-term birth?

A. Typically by protocol spontaneous abortion would have to happen before 20 weeks. Once you go beyond 20 weeks it would be considered a pre-term labor.

Q. Okay. Continuing on quotation:

> "Spontaneous pre-term birth occurred in seven"—or, I am sorry—"2 of 17 (11.8 percent) pregnancies in the intact dilation and extraction group compared to 2 of 45 (4.4 percent) in the dilation and evacuation group."

Doctor, is this difference in the rate of spontaneous pre-term births statistically significant in the context of this study?

A. Again, because the numbers were so small, it doesn't have the power to demonstrate that. You can see that by the fact that they said the p value was .3. For it to be a statistically significant the p value would

have to be under .05. And you can't demonstrate that when you have such small numbers.

Q. Can you draw any inferences at all from these figures?

A. What I would have to say is, again, you are saying that [1107] 11.8 percent, almost 12 percent of women who had an intact D&X had a premature labor and delivery.

The women who had a D&E, 4.4 percent had a premature labor and delivery. That is almost a three-to-one increase. It is clearly a trend. It would certainly get my interest and I would be concerned. And, again, if anything, it would tend to say D&X is more risky for the mother and more likely to cause premature labor, which is one the most serious complications in obstetrical situations.

Q. Doctor—

A. It is not statistically significant, but it is certainly a trend that we should look at. And, again, further studies should be carried out, because if this trend is true that would be strong evidence that intact D&X is not as safe for the mother.

Q. Doctor, is it your understanding that the Chasen article has not yet been published?

A. To my knowledge it has not been.

Q. Does that status affect at all your views to the strength of the study?

A. The reason we like to actually review published studies is then they are out in the general medical community. In a study like this it would definitely be discussed at journal clubs. You get more input and feeling

of the medical community on the significance of this. And sometimes controversial articles * * *.

* * * * *

[1109] fetus.

And then, the mother went to additional chemotherapy and additional things were done.

Q. So you have never encountered a situation where the pregnancy had to be terminated before viability because of a maternal health condition?

A. I have not.

Q. You may have said this already, Doctor. How many live babies have you delivered?

A. Well over 3,000.

Q. Doctor, have you ever considered whether a particular pregnancy should be terminated because of a fetal anomaly?

A. There I have had patients that I do genetic amniocentesis. I do get the information back at 18, 19 weeks. I have had patients who, because of the information that was received, have decided to terminate the pregnancy.

And they are referred to my maternal fetal medicine physicians. And those are carried out.

Q. Doctor, are there maternal health conditions for which a termination of pregnancy would be indicated to save the life of the mother?

A. There are. There are fortunately very few and far between, and very remote. Most of the time as both it says in my article and in my quotes from Stubble-

field's chapter, that there are very few indications if you are in the time frame at * * *.

* * * * *

[1111]

MS. GARTNER: —This is hearsay for him to be testifying about what other physicians said in their declarations or depositions.

THE COURT: Sustained.

BY MR. SIMPSON:

Q. Doctor, in your practice have you seen a need for the use of the intact D&X method?

A. I have never seen a situation where an intact D&X method was necessary to be performed.

Q. We mentioned earlier conditions where pregnancy termination may be indicated to save the life of the mother. Are there also maternal health conditions for which termination of pregnancy would be indicated to preserve the health of the mother?

A. That is possible.

Q. Doctor, does your practice involve high risk obstetrics at all?

A. My practice does involve high risk practice.

Q. What is high risk obstetrics?

A. Depending—and there are various definitions, but the severity of the patient, diabetes in pregnancies, some heart conditions.

I have a patient now that has a biliary—it is the tract from the liver—and has significant potential risk. But she has been a patient of mine. This is a not usual [1112] condition. I had her see a maternal fetal

medicine physician in consultation, but she returns to me for care.

When we started, the subspecialty of maternal fetal medicine did not even exist. So initially we were the treating maternal fetal medicine physicians de facto.

Q. Doctor, how many physicians are there in your practice group?

A. There are, in my wider group, 28 obstetricians and gynecologists.

Q. Have you heard of any circumstances in your practice group that call for the use of intact D&X?

A. I have not.

Q. Doctor, are there emergency situations in which a fetus or infant must be removed as quickly as possible to save the mother's life or health?

A. There could be acute hemorrhage, those kinds of things, that you would need to resolve that issue.

Q. Could the intact D&X method be used for those situations?

A. It could be used, but it would never be the only choice and never be the best choice.

Q. Based on your understanding of the length of time that it takes to prepare for an intact D&X, could it be used in an emergency situation?

A. It could not be used in an emergency situation because, as I said it, takes three days to do that procedure.

* * * * *

[1121]

A. It does.

Q. I'd like to read a few sentences from your JAMA article.

That's Exhibit A-55. If you can just turn to that to make sure I am reading it correctly.

I will read from the second page left hand column, the last paragraph in that column.

> "Beyond the argument of potential viability, many pro-choice organizations and individuals assert that a woman should maintain control over that which is part of her own body (i.e., the autonomy argument). In this context, the physical position of the fetus with respect to the mother's body becomes relevant. However, once the fetus is outside the woman's body, the autonomy argument is invalid. The intact D&X procedure involves literally delivering the fetus so that only the head remains in the cervix. At this juncture, the fetus is merely inches from being delivered and obtaining full legal rights of personhood under the U.S. Constitution?"

Are those your words, doctor?

A. Correct.

Q. Is that your testimony today?

A. Correct.

* * * * *

[M. LEROY SPRANG, M.D.—CROSS EXAMINATION]

* * * * *

[1122]

Q. And, in fact, you feel so strongly about the preferability of induction to D&E after 20 weeks that if you have a patient that has a fetal death in utero after 20 weeks you probably wouldn't even bring D&E up because you think there is, in your belief, induction is the safer process for the patient at 20 weeks or greater; isn't that right?

[1123]

A. Correct.

Q. And if a discussion of D&E versus induction did come up, you would encourage your patient to have an induction because you think it's safer?

A Correct.

Q. Okay.

And you believe that in terms of deciding which procedure to choose, the only prudent thing for an intelligent woman who trusts her doctor to do is to strongly rely on what her doctor is saying because patients don't have enough of the background to understand the nuances of the recommendation.

Is that right?

A. Correct.

* * * * *

[1133]

* * * * *

Q. Let me read this to you. The report of the Task Force states at the bottom of page 196:

> "To minimize uterine or cervical perforation either from instruments used during the D&E or through piercing by fetal parts, some physicians use a form of D&E that has been referred to in the popular press as intact dilation and extraction, (D&X)."

I am going to skip the next sentence which sets forth ACOG's definition of that procedure, and I will continue to read at the bottom of the page.

> "This procedure may minimize trauma to the woman's uterus, cervix, and other vital organs. Intact D&X may be preferred by some physicians, [1134] Particularly when the fetus has been diagnosed with hydrocephaly or other anomalies incompatible with life outside the womb."

Did I read that correctly, Dr. Sprang?

A. Yes.

Q. And this was what the AMA Task Force Report stated; is that correct?

A. Correct.

Q. And then while we are on this page 197, Dr. Sprang, why don't we look at the paragraph, I think it is two paragraphs down that begins with the word "Hysterotomy and hysterectomy."

Do you so that?

A. Yes.

Q. Let me just read to you the first sentence of that paragraph and you can tell me if this was what the AMA Task Force wrote. Now I am reading:

> "Hysterotomy and hysterectomy have been used to terminate pregnancy but are not used routinely as a form of abortion because maternal mortality and morbidity associated with these procedures are significantly greater than those associated with other procedures used to induce abortion."

And is that—did I read that correctly Dr. Sprang?

A. Correct.

[1135]

Q. That is what the AMA Task Force wrote, correct?

A. Correct.

Q. And does that reflect the consensus view of the AMA Task Force?

A. Correct.

* * * * *

[1147]

* * * * *

Q. Dr. Sprang, I am going to ask you, again, I'm going to test your eyesight and ask you to look back at the AMA report, and look specifically at page 199. The third, I think it's the third paragraph on that page begins with the word "cervical incompetence."

Dr. Sprang, can we do it again? I will read it to you and tell me if I've read it correctly?

A. Sure.

Q. The report, and this is, again, from the AMA Task Force Report:

> "Cervical incompetence and compromised subsequent pregnancies are important, but unresolved concerns related to abortions performed in the second or third-trimester. Unfortunately, there is little research on whether these complications are more likely to result from D&E (or intact D&X) or from labor induction techniques."

[1148]

And that's what the AMA task force wrote on this subject; is that correct?

A. Correct.

Q. Does this reflect the consensus view of the AMA task force?

A. It is unresolved, in fact, it is unresolved and I agree with it.

* * * * *

[1162]

* * * * *

The AMA Task Force on which you served gave thorough consideration to ethical issues related to both intact D&E and other late abortion procedures; is that correct?

A. Correct.

Q. Okay. And I would like you to take a look at page 208 of that report.

Do you want to take a look at the last paragraph on that page, Dr. Sprang.

A. Do you want me to read it?

Q. Well, no. I am just going to ask you a question. And if we need to, we will read it. But let me ask you: it is true, is it not, that the report states that the ethical arguments about intact D&E do not lead to one clearly preferred ethical position?

A. The way the report is written it left it open.

Q. Right. So—and the committee writing the report did not reach consensus about the ethics of intact D&E; is that right?

A. Correct.

* * * * *

[1163]

A. This was a board of trustees report. It went back to the board of trustees for their final approval.

Q. Okay. But my question for you is whether the task force that you were on that wrote this report, you did not reach consensus about the ethics of intact D&E, did you?

A. Correct.

Q. Now, I think in your deposition, Dr. Sprang, you testified that you have two ethical concerns with intact D&E. I think you said that the first one is that you believe it is unethical to cause fetal demise once any part of the fetus is outside of the uterus; is that right?

A. Is that an actual quote? I would not have said "any part of the fetus." I would have said I believe it is unethical to kill the fetus outside of the mother, when the fetus is outside of the mother. So the wording is relevant.

Q. So your testimony is you think the ethical concern comes about when the demise occurs when any part of the fetus is outside the body of the mother?

A. You keep adding "any part of the fetus."

Q. I'm sorry.

A. And I said: "When the fetus is outside of the mother."

Q. Okay. So, you mean, that the ethical concern is when the entire fetus is outside of the body of the mother?

A. Sufficient to mount that it is in the process of delivery where it becomes a question of: is it or is it not delivered?

* * * * *

[1167]

* * * * *

Q. And would you agree that at an institution of the caliber of Northwestern it is unlikely that unsafe medical procedures are being taught?

A. Subject to obviously interpretation of what is safe and what isn't safe, most of the information we have seen and certainly the most recent article would say they are similar, D&E and D&X were similar in their complication rate. But there might be a trend for the D&X to have more complications. But it is certainly not an established fact.

Q. So you would agree that D&E and intact D&E are comparably safe?

A. I am not sure I would go that far. I would say there is not absolute proof that D&X is less safe.

* * * * *

Supreme Court, U.S.
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AUG 3 - 2006
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No. 05-1382

In the Supreme Court of the United States

ALBERTO R. GONZALES, ATTORNEY GENERAL,
PETITIONER

v.

PLANNED PARENTHOOD FEDERATION OF AMERICA,
INC., ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

JOINT APPENDIX
(VOLUME 4)

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CERTIORARI GRANTED: JUNE 19, 2006

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UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C 03-4872 PJH

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. AND PLANNED PARENTHOOD GOLDEN GATE, PLAINTIFFS

v.

JOHN ASHCROFT, ATTORNEY GENERAL OF THE UNITED STATES, IN HIS OFFICIAL CAPACITY, DEFENDANT

TRANSCRIPT OF PROCEEDINGS
Monday, Apr. 12, 2004
Volume 8

BEFORE THE HONORABLE
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* * * * *

[1188]

THE CLERK: Please take the stand. Please state your name for the court.

THE WITNESS: My name is Dr. Elizabeth Shadigian.

THE CLERK: Spell your last name.

THE WITNESS: S-H-A-D-I-G-I-A-N.

THE CLERK: Thank you.

[ELIZABETH SHADIGIAN, M.D.—DIRECT EXAMINATION]

BY MS. CLARK:

Q. Good morning, Dr. Shadigian.

A. Good morning.

Q. Could you please tell the court what you do for a living?

A. Yes. I'm a faculty member at the University of Michigan in the school of medicine, and I'm a physician, an obstetrician gynecologist that takes care of pregnant women and women who aren't pregnant for their gynecological needs.

Q. How long have you been at the University of Michigan?

A. I will be completing my 10th year at the University of Michigan in June of 2004.

MS. CLARK: May I approach, your honor?

THE COURT: Yes.

BY MS. CLARK:

Q. I've just shown you what has been marked as Defendant's Exhibit A-6. Is this a copy of your C.V.?

A. Yes, it is.

Q. Did you create it?

[1189]

A. Yes, I did.

Q. Does it accurately reflect your education, work experience and publications?

A. Yes, it does.

MS. CLARK: Defendant moves to admit into evidence Defendant's Exhibit A-6.

THE COURT: Any objection?

MS. PARKER: No.

MS. KRASNOFF: No objection.

THE COURT: Admitted.

THE CLERK: A-6 into evidence.

(Defendant's Exhibit A-6 was received in evidence.)

BY MS. CLARK:

Q. Dr. Shadigian, will you explain briefly your educational background?

A. Yes. I went to Purdue University for undergraduate education and received a bachelor of science degree in chemistry. And then, I went on to the Johns Hopkins School of Medicine and received my medical degree in 1990. And then, received postgraduate training at an obstetrics and gynecology residency program in Baltimore called Franklin Square Hospital Center, as well as the Johns Hopkins Hospital.

Q. Do you have any board certifications?

[1190]

A. Yes.

Q. What are those certifications?

A. I am boarded in obstetrics and gynecology.

Q. And are you licensed to practice medicine in Michigan?

A. Yes, I am.

Q. And was it immediately after your residency that you came to work at the University of Michigan?

A. Yes. I became a faculty member basically right after residency.

Q. What was your initial position?

A. I was clinical assistant professor of obstetrics and gynecology.

Q. And what is your position now?

A. I'm clinical associate professor of obstetrics and gynecology.

Q. Does that mean you have been promoted since you have been at the University of Michigan?

A. Yes, in 2002 I was promoted.

Q. Dr. Shadigian, could you please explain what you do as a clinical associate professor at the University of Michigan, first with respect to your clinical practice?

A. Yes. Basically, I do three things at the University of Michigan. One is actually take care of women in terms of my scope of practice in obstetrics and gynecology. So that is the clinical care piece. [1191]

I also teach medical students and residents, and I also do research in various subjects.

Q. Could you describe the kinds of patients that you treat?

A. Yes, I certainly can. I have a broad range of practice. I'm a generalist. I do high risk obstetrics, so I take care of women with different medical diseases in pregnancy such as high blood pressure, diabetes, certain connective tissues disorders or rheumatological disorders. I take care of twin pregnancies, and I take

care of normal low risk pregnancies, as well. I do prenatal care of these women, as well as their delivery and postpartum or aftercare after a pregnancy.

And, in addition, I do generalist gynecology, so I take care of patients with chronic pelvic pain. I operate on women who need certain surgical procedures. In addition, I do family planning, such as discuss with women if they want to avoid pregnancy what options they have. And also just do well women gynecological care.

Q. Approximately how many babies have you delivered in the last year?

A. Probably between 100 and 150.

Q. How many of those are vaginal deliveries?

A. Probably about eighty percent of them.

Q. And twenty percent by cesarean section?

A. Yes.

[1192]

Q. And have you ever vaginally delivered babies in a breech presentation?

A. Yes, I have.

Q. When was the last time you did that?

A. Probably about two months ago.

Q. Can you briefly describe a vaginal delivery when there is a breech presentation?

A. Yes. First we assess what part of the baby is coming down, so if it is actually the feet or the bottom or one foot or two feet and where the feet are with respect to the bottom.

And then, we go ahead and deliver the presenting part. So if it's the bottom, we will deliver that, and then we bring the feet out. We deliver up to about the navel and then we pull the baby gently down in a towel, and then we reach up and put our fingers down the humerus or upper arm and basically hook near the elbow the baby's arm and have it come out. And then, we rotate the baby and bring out the other arm. And then, once the head is delivered, once the—excuse me—the shoulders are delivered, then we would go ahead and proceed to deliver the baby's head. And basically we want to deflex or tip down the head to reduce the diameter of the baby's head coming out.

Q. Are most of the patients that you see, are most of them referrals to you?

A. Some are referrals but some are patients. I have been [1193] there for 10 years now, so I have a lot of women I have followed for many years.

Q. Do you ever refer patients to maternal fetal medicine specialists?

A. Yes, I do.

Q. What kind kinds of patients do you refer to MFM's?

A. There are some women with more severe medical problems, such as complicated cardiac disease, women who may have triplets or quads, and three or four babies inside.

In addition, there are certain connective tissue disorders like severe lupus, which I would refer because of their specialized training as well as women who are HIV positive.

Q. Dr. Shadigian, you mentioned that you provide family planning to your patients. What kind of family planning do you provide to them?

A. Basically I provide the full range of family planning, so anywhere from explaining how natural family planning works, offering them barrier contraceptives such as diaphragms and condoms, through births control pills, intrauterine devices and sterilization.

Q. Doctor, are there occasions when caring for a patient you have needed to terminate a pregnancy?

A. Yes, there have been.

Q. And in those instances have you ever needed to terminate a [1194] pregnancy where the fetus was alive? That the termination—excuse me—was necessary to treat a maternal health condition?

A. Yes, I have.

Q. What reasons have you needed to terminate a pregnancy?

A. There is a wide variety of reasons. One example might be an infection in the mother's uterus or around the baby called chorioamnionitis. There are other medical disorders like preeclampsia when there is high blood pressure and swelling in the woman as well as protein in the urine that may necessitate an earlier birth.

And then, there may be some other situations where a woman may have cancer and need to initiate chemotherapy and the baby is a far enough along to be delivered to help care for the mother.

Q. Dr. Shadigian, have you ever diagnosed fetal anomalies in the pregnant women that you have treated?

A. Yes.

Q. What kinds of fetal anomalies have you detected?

A. Again, a wide variety in the last 14 years. Some things are genetic like trisomy 21, or 18 or 13. Turner's syndrome is another example of a kind of genetic problem.

And then, there are actual structural problems, so things like having the bowels outside the baby, such as encephalocele or gastroschisis are other examples of anomalies. [1195]

In addition, I have taken care of a mother with conjoined twins, which is where instead of two babies are separated they were connected both at the chest wall and abdomen, as well.

Q. Through your training and background and your clinical experience, have you become familiar with different methods of terminating pregnancy?

A. Yes, I have.

Q. What methods have you utilized to terminate pregnancy?

A. The full range of methods are—or what I would use generally, some things are as common and simple as a cesarean section done earlier than usual. And other would be procedures such as D&C's, D&E's, which is dilation and evacuation and also medical induction of pregnancy. I should say of labor and pregnant.

Q. Taking the D&C first, what do you mean by "D&C"?

A. The letters D&C, the acronym stand for dilation and curettage, which is the french word "to scrape." And so that means dilating or opening the cervix of a woman and then going ahead and removing the contents of the uterus by sharp or suction curettage.

Q. And what is your experience with D&C—with D&C's going back to medical school?

A. In medical school I observed several D&C's on live babies for termination of pregnancy that were elective. However, I [1196] didn't directly participate by holding instruments. Instead, I took my training in that on babies that had already died.

Q. And approximately D&C's have you done in your career?

A. I'm sure it is in the hundreds range.

Q. And do you continue to perform D&C's in your current practice?

A. Yes, I do.

Q. Now, next, turning to the D&E, what do you mean by "D&E" or dilation and evacuation?

A. The way I use that term is generally when they are in the second-trimester of pregnancy where usually laminaria or osmotic dilators are used the day before the procedure to open the cervix of the women, and generally that is placed as gently as possible with the laminaria placed being inside the cervix, sometimes with traction on the cervix and sometimes without.

And then, the next day in the operating room a woman is taken to the operating rōom, a speculum is

placed in the vagina. The laminaria are removed, and then a device is decided upon which to put traction on the cervix to straighten the cervix angle with the rest of the uterus out, and then with a series of instruments the baby is disarticulated or removed in pieces with certain kinds of forceps. And then, the fluid in the membranes and the placenta is also removed. And sometimes we use ultrasound guidance for this procedure, as well.

[1197]

Q. Could you please explain to the court your experience in performing D&E's?

A. Yes. First as a student I watched quite a few D&E's because I was interested in finding out how they were performed and why they are performed on different kinds of women in different situations.

And then, as a medical student, especially as a resident, I actually made it a point to learn how to do this procedure properly. And I tried to participate in as many as I possibly could as a resident because I knew this was my window of opportunity to learn.

So I probably participated in 30 to 50 as a resident over four years.

Q. And approximately how many times in your career have you performed a D&E procedure?

A. Total number of times probably 60 to 70.

Q. And has this always involved dismemberment of the fetus?

A. Yes.

Q. In the D&E procedures that you have performed or participated in, have those fetuses been alive or dead?

A. The ones I actually held the instruments and actually did the actual procedure the baby had been dead.

Q. And when you observed at one of those observations, observations of D&E's performed on live fetuses?

A. Yes, many were.

[1198]

Q. Is the extraction part of the D&E procedure that you perform when the fetus has died different from the D&E procedure performed on a live fetus?

A. The actual technique is the same, but the way the baby's disarticulated, pulled apart, would probably be somewhat easier with a dead baby than it would be on a live baby.

Q. And would that depend on how long the baby has been dead for?

A. Yes, it would.

Q. Up to what gestational age have you observed a D&E on a living fetus?

A. Between 20 and 22 weeks.

Q. Next, turning to the induction procedure. In general terms, what do you mean by "medical induction"?

A. Medical induction of labor is when certain medicines are given either orally, through the mouth, vaginally, or even instilled into the amniotic fluid

around the baby that will make the body have contractions and expel the baby physiologically.

Q. What is your experience with the induction method of termination?

A. Well, as a student I actually rotated at something called the Francis Scott Key Medical Center or the County Medical Center, and they did quite a few instillation medical induction procedures because they actually did the most number in [1199] Baltimore, so I got direct opportunity to see what their protocols were, to actually talk to women undergoing the procedures. So I observed several during that time. Probably ten to twenty of those at the Francis Scott Key. And then, during residency is when things shifted somewhat. And instead of just instillation, we also shifted over to more prostaglandins. So, of course, we have used oxytocin or pitocin for many years for inductions of labor.

Q. Do you currently use the medical induction for termination of pregnancies?

A. Yes, I do.

Q. And how frequently do you use that method?

A. Depends on the clinical situation, but as the need arises sometimes on a weekly basis we need to induce women's labors because of medical problems or problems with the baby.

Q. Currently, what agent or agents do you use when performing an induction for termination of pregnancy?

A. The most common two medications we use are the misoprostol, which is one of the prostaglandins that

we have been talking about, and the other one is oxytocin.

Q. Is oxytocin is a prostaglandin?

A. No, it is not. It is a separate category of medication.

Q. And just to be clear—you touched on this—how are those agents, the misoprostol and oxytocin, administered to the women?

[1200]

A. The misoprostol is given either orally to a woman or intravaginally, the way we use it. And then, the oxytocin is an IV drip.

Q. When you say an "IV drip," is this different than instillation?

A. Yes. It means an intravenous going to a women's vein with a mixture of some kind of saline solution plus the medication itself: oxytocin.

Q. And for approximately how long have you been performing inductions with prostaglandins and oxytocin?

A. For my entire career of practice, with one or both. Fourteen years, approximately.

Q. When was the last time you performed an induction using an instillation method?

A. Probably the last time I saw instillation methods were when I was a resident.

Q. So, approximately what year?

A. In the early '90's. And in medical school in the late '80's.

Q. And when there is an instillation, can you explain where the instillation—where the injection is installed into the woman?

A. So generally, it is very similar to an amniocentesis. Instead of fluid being drawn off from around the baby, instead medications would be injected around the baby into the amniotic [1201] fluid.

Q. Do you consider inductions with the use of prostaglandins and oxytocin different in any material way from the instillation methods?

A. Well, because the women's uterus is not punctured with a needle, it is a different process. And so one might assume that there might be different complications and different amounts of medications used, for example.

Q. Have you used the medical induction procedure when the fetus is previability?

A. Yes, I have.

Q. And have you used the medical induction procedure when the fetus is postviable?

A. Yes.

Q. What do you understand "previable" to mean?

A. Generally, you say "previable" is any time before a baby can survive outside the mother's uterus. So in current, general practice for neonatal practice we usually say viability is at approximately 23 weeks gestation.

Q. Do you currently perform more inductions than D&E's?

A. Yes, I do.

Q. Why is it that you've had the occasion to perform more inductions than D&E's in your practice?

A. In general, the way it's set up at University of Michigan, we get transfers of very sick women. And I take call with the [1202] residents. We call it "supervisory call" at nighttimes. So whenever there is transfers of sick women, many of them—I would say in a year we have a few in the late second-trimester who are quite sick. Many more in the third-trimester who are sick and, in fact, need to be delivered.

And because we have a very high level neonatal unit we get transfers all southern Michigan and northern Ohio to our institution.

Q. And what does that have to do with whether or not you perform induction more than D&E?

A. The data has shown that in the late second-trimester of 20 weeks and above that actual medical induction's a safer procedure for women rather than the dilatation and evacuation.

So when we are presented with patients who have medical problems in the late second-trimester, it has been our habit because of the safety data to use medical induction of labor rather than D&E to end a pregnancy.

Q. Dr. Shadigian, focusing on your experience with pregnancy terminations while in medical school, and in your residence, did you make a special effort—you have already touched on this, but did you make a special effort to learn about pregnancy termination?

A. Yes, I did.

Q. Why did you make that special effort?

A. I knew it was something that was really common for women to [1203] choose to have an abortion, that in the first or second-trimester women electively decide to have an abortion. And they also decide because of problems with the baby and problems with their own health. So I wanted to make sure I understood all of the ramifications that making those decisions would have on a woman.

And because about 43 percent of women have an abortion by the time they are age 45, I knew I would have a lot of women in my practice who had had abortions. And so I needed to know how to take best care of them, both during the time they are making important decisions and afterwards, and then in the long run.

Q. While you were in Baltimore training, at what institutions did you work where abortion services were provided?

A. At the Johns Hopkins Hospital I was a medical student and Francis Scott Key Medical Center, the county hospital, as well.

Q. And—

A. And one more thing. Did you ask me just for medical school or medical school and residency?

Q. Well, I was wondering during your training just at what institutions did you work where abortion services were provided?

A. And also Franklin Square Hospital, as well.

Q. What kinds of patients did you see and treat?

A. Basically, the full range of patients that they would have [1204] at that institution, so both elective

terminations, as well as women who were sick and women who had babies with anomalies.

Q. Did you see women with teen pregnancies, in particular?

A. Yes. In fact in my residency we had the unfortunate but needed service of providing pregnancy care and labor and delivery care to a high percentage of teen women. In fact, Baltimore had and still has one of the highest teen pregnancy rates in the country.

And so that was one of the things that we especially took care of were teens.

Q. Was the induction method of termination of pregnancy, was that frequently used at the Johns Hopkins Medical Center?

A. Yes, it was.

Q. Now, I would like to ask you some questions about your teaching responsibilities. Could you please generally describe your teaching responsibilities at the University of Michigan?

A. There are basically four sets of students and/or residents that I teach. One are undergraduate students where I guest lecture in women's studies courses, psychology courses, sociology courses and graduate-level teaching in the nurse midwifery program as well as in certain psychology Ph.D. thesis I have been on.

And then, in the medical students I lecture on interpersonal violence issues, including domestic violence, sexual assault, child abuse and elder abuse. I run a [1205] second-year course in this.

The third year I teach the students rotating through our department in OB/GYN by both hands-on

learning and teaching, as well as giving lectures every six weeks in both breast-feeding and more complicated domestic violence issues.

And, then, finally I run a fourth-year medical student elective called "primary care OB/GYN" where senior students get to pick different topics they are interested in and understand them from both clinical and didactic angles, basically.

And those are the student areas. And then, the residents I teach—the most time I teach are actually OB/GYN residents that we have in our program.

And then, I have had the occasion on an ongoing basis to teach family practice residents and internal medicine and pediatric residents, as well.

Q. And with the residents, what kinds of things do you teach to the residents?

A. Just the full range of what I do in the office setting and in the inpatient setting, I will discuss with the residents. But how it sort of works where I am set up is that it feels that if you are a woman coming to my office it feels like a private office. That you just see me most of the time in the office.

Sometimes I will have a student with me, sometimes I [1206] won't. But then with the residents I am doing more inpatient work, meaning supervising GYN procedures, labor and delivery procedures. And then, sometimes people consult me, especially women who have been abused, because that is my other area of interest.

Q. And do you supervise residents in performing pregnancy terminations?

A. If the baby has already died and it's my own patient I would have her come to the operating room after I've consented her, and one of the residents would scrub in and assist me in most procedures.

And, in addition, if I am on call, supervisory call, and someone is transferred in and they need to have a medical induction of labor, then I would supervise the residents in that case, as well.

Q. Doctor, do you also teach about abortion complications?

A. Yes, I do.

Q. And who do you teach?

A. Well, it would depend at the time, but many times women are readmitted after having a termination of pregnancy, for whatever reason, with a fever, with hemorrhaging, with other complications that are common, and we need to go back and do another procedure, so a curettage or scraping to get the rest of the placenta out.

So there is the hands-on kind of teaching when the [1207] women is readmitted. And then, there has been other occasions when I have been asked to speak in front of different groups to talk about abortion complications because of the paper I have written.

Q. What kinds of groups are those that you've lectured to about abortion complications?

A. I have lectured to different groups of ACOG, the American College of Obstetricians and Gynecologists. I have given grand rounds in medical institutions. And then, any groups that have asked me to come, and if I can put them on my schedule I have gone ahead and lectured to different groups.

Q. What kinds of abortion complications have you treated in your practice?

A. The most common ones are infections after an abortion procedure, retained placenta, meaning that there is still some kind of placenta or different parts of the baby that can be left inside. And then, there are other things that I do attribute to abortion, such as women who have had early births in another pregnancy and women who have placenta previa, for example.

Q. I would now like to touch on your research responsibilities. In what areas have you performed research and writing?

A. My two biggest areas of research are on violence against women, so I have done different studies and then published them [1208] on issues around violence against women. And also on abortion complications. One thing that I am sort of subspecialized in is something called "systematic review," so that when we look at publications previously published in peer reviewed journals I try to take not just one or two articles and synthesize them, but do a whole literature search and gather all the articles on a certain topic and then try to make sense of what they show in aggregate.

So I have done that on both issues around violence against women and issues around abortion complications.

Q. How does your research in the areas of domestic violence relate to your OB/GYN practice?

A. Again, violence against women is a very common problem, both in the United States and worldwide. So I knew when I was a resident, a medical student that I would see a lot of women who have been abused.

And so, again, to take the best care of women I can, I need to be able to understand their personal situation in terms of: Is it safe at home? Have they possibly been assaulted as a girl or as a young woman, because I am going to be operating on them and I am going to be someone that they really need to trust.

And if they can't trust that I care about those very intimate and scary areas of their lives, then it is going to be hard for them to trust me about the medical things. [1209]

So I think they go together. And that is part of why I wanted to know about abortion, because, again, it is one of these very intimate and personal areas where, you know, women need to have a lot of support in their physician.

Q. Have you written any articles about the long-term complications of abortion?

A. Yes, I have.

Q. What is that article?

A. In January of 2003, myself and two other co-authors from University of North Carolina got published an article looking at the long-term, both physical and psychological, complications of abortion, called "A Review of the Evidence," which is, again, one of the systematic reviews.

Q. Was that peer reviewed?

A. Yes, it was.

Q. Are you a journal reviewer for any publications?

A. Yes.

Q. Which journals?

A. I have been asked to be journal reviewer for many. Some examples are the Green Journal, which is one of the major OB/GYN journals called Obstetrics and Gynecology. And then, the American Journal of Obstetrics and Gynecology, The Mayo Clinic Proceedings, The Female Patient and several others.

Q. Do you belong to any professional organizations?

[1210]

A. Yes, I do. Probably the one that is most important to me and the one I am most intimately involved in is the American College of Obstetricians and Gynecologists. In addition, I'm part of many other organizations, as well.

Q. Are you also a member of AAPLOG?

A. Yes. AAPLOG is the American Association of Pro-Life Obstetricians and Gynecologists. And, in fact, is a part of ACOG, the main group. It's a special interest group of ACOG.

Q. Are you a fellow of ACOG?

A. Yes, I am.

Q. Briefly, why did you decide to specialize in obstetrics and gynecology?

A. Well, women are near and dear to my heart, I guess possibly because I am one, too. But just I was fascinated by the breadth of what we do to take care of women, both on the obstetrical end and the gynecological end.

And that I liked being able to follow women over time and give them time to get to know me personally and so I could help them with major life decisions and be a sounding board for medical information, too.

Q. Turning to the partial-birth abortion procedure, what do you understand the partial-birth abortion procedure to be?

MS. KRASNOFF: Objection, foundation.

THE COURT: Sustained.

[1211]

THE WITNESS: In short—

THE COURT: Just a moment.

THE WITNESS: Oh, I'm sorry.

THE COURT: She'll ask you a different question.

BY MS. CLARK:

Q. Dr. Shadigian, have you heard the term "partial-birth abortion"?

A. Yes, I have.

Q. And what do you understand "partial-birth abortion" to mean?

MS. KRASNOFF: Objection, foundation. She's not been qualified to testify about that area.

THE COURT: You haven't even told us yet what you are offering her to testify about.

MS. CLARK: I can jump to that. Your honor, defendant offers Dr. Shadigian as an expert in obstetrics and gynecology, pregnancy termination and abortion complications.

THE COURT: All right. And do you have an objection?

MS. KRASNOFF: We would like to voir dire on pregnancy termination.

THE COURT: And not abortion complications?

MS. KRASNOFF: No, your honor.

THE COURT: All right. You may do so.

MS. KRASNOFF: As they relate to specific methods, [1212] perhaps. But not—

THE COURT: Opposing counsel is going to ask a few questions before I determine what areas you are competent to testify as an expert in.

[VOIR DIRE EXAMINATION]

BY MS. KRASNOFF:

Q. Good morning, Dr. Shadigian. I am Helene Krasnoff. We met at your deposition.

In your career, you have performed between 20 and 40 previability abortions where the fetus was alive at the beginning of the procedure; is that correct?

A. That's approximately correct, yes.

Q. And you testified on direct that you performed terminations of pregnancy weekly, but those are not previable; is that correct?

A. Correct.

Q. Actually, on previable fetuses you perform about two or three per year; is that correct?

A. That's correct.

Q. And each and every one of those is by the induction method; is that correct, where the fetus is alive?

A. Where the fetus is alive, that's correct.

Q. In fact, you have never performed a D&E procedure on a live fetus; is that correct?

A. That is correct.

[1213]

Q. And you have never performed a hysterotomy on a live fetus; is that correct?

A. Not that I can recall.

Q. So your only experience performing D&E's are on fetuses that have already demised; is that correct?

A. Yes, except for when I was observing others doing D&E's on live babies.

Q. So your only experience actually performing them yourself; is that correct?

A. That is correct.

Q. As a faculty member at the University of Michigan over the past 10 years, you have only supervised or participated in between 10 and 20 D&E's where the fetus had demised; is that correct?

A. That is correct.

Q. So, if you average that out that supervision with a demised fetus happens between zero and two times each year; is that correct?

A. That is correct.

Q. And the latest gestational age at which you have actually performed a D&E on a dead fetus at the University of Michigan in the past 10 years is at 17 or 18 weeks; is that correct?

A. That is correct.

Q. And isn't it true that some D&E's may require surgical skills beyond your practice such that you would refer those to [1214] the maternal fetal medicine specialists?

A. That is correct.

Q. Turning to intact D&E, you yourself have never performed an intact D&E; is that correct?

A. That is correct.

Q. And you haven't supervised anyone else performing an intact D&E, have you?

A. That is correct.

Q. You haven't observed an intact D&E abortion being performed; is that correct?

A. Not live, that's correct. I have not seen one live; that is correct.

Q. And you haven't been taught the intact D&E procedure, have you?

A. That is correct.

Q. And you haven't taught it to any medical students or residents, either, have you?

A. That is correct.

Q. And you have never discussed intact D&E with any physician who performs intact D&E, have you?

A. That is correct.

Q. And you don't actually personally know any physician who performs intact D&E, do you?

A. Probably not.

Q. And you haven't discussed the intact D&E procedure with any [1215] other physician at the University of Michigan, whether he or she performs intact D&E or not?

A. That is correct.

Q. And prior to December 22, 2003, you never done a literature search about intact D&E abortions, had you?

A. That is correct.

MS. CLARK: Your honor I am just going to object. We haven't sought to qualify her as an expert on the technique of the D&X procedure, so I think it is outside the scope and not particularly relevant.

THE COURT: Counsel, this is voir dire. This is voir dire. She can ask those kinds of questions.

BY MS. KRASNOFF:

Q. And at that time back in December, you also hadn't done a literature search for the purpose of comparing the safety of second-trimester abortion procedures; is that correct?

A. That is correct.

Q. So it wasn't until after you were contacted to testify in this case that you performed the literature reviews which form the basis of the opinions you are going to offer today; is that correct?

A. That is correct.

Q. And, in fact, it was because of that unfamiliarity that it took you more than 35 hours from the time you were contacted until your expert report was prepared to prepare it; is that [1216] right?

A. I don't know what you mean.

Q. I could show you something that might refresh your recollection.

Dr. Shadigian, I have shown you an invoice for the time spent on this case. Does that refresh your

recollection about the time you spent preparing your expert report?

A. I believe you asked the question—yes. But you asked a question about if it was just all spent on literature search, I thought.

Q. Oh, I'm sorry. Did you not spend 35 hours of work from when you were first contacted until you signed your expert report on January 16th?

A. That is correct.

Q. And you hadn't previously, prior to December, done any research related to these methods of abortion in the second-trimester; is that right?

A. Not formal, yes.

MS. KRASNOFF: Your honor, plaintiffs believe that Dr. Shadigian does not meet the standard laid out by the court last week on being able to testify about how intact D&E abortions are performed. She has never performed, supervised, observed, taught, been taught or even spoken to any physician who performs that procedure.

We do not object to Dr. Shadigian being qualified as [1217] an expert in obstetrics and gynecology, generally. And we do not object to her speaking generally about her research in the complications related to abortion. As they relate to specific procedures, such as intact D&E, we believe there is no basis for that.

However, as the court permitted last week with Dr. Sprang, we don't object to her providing expert opinion on the safety of intact D&E based on her general expertise in OB/GYN, nor her briefly setting forth her understanding of the procedure in order to

offer those opinions that are based on external sources only.

But her testimony regarding how intact D&E abortions are performed, we submit, would thus not be for the truth of how that procedure is, but rather that those are the bases of how she understands it for her opinions.

THE COURT: All right. Any response, Ms. Clark?

MS. CLARK: I might have missed something. I am not sure if they are objecting to the abortion complications and her views on abortion complications. But I think her research—she wrote an article about—specifically about abortion complications. Whether an expert is qualified is based on knowledge, skill, experience and training. And she has had sufficient training in abortion complications. She has treated patients with abortion complications.

With respect to pregnancy termination, as she [1218] testified she has performed medical induction when it was been necessary for medical health conditions for the woman. She's observed D&E's on live fetuses. She's performed D&E's—

THE COURT: I think you weren't paying attention to her objection.

First of all, did you object to the witness being qualified on the question of abortion complications?

MS. KRASNOFF: Not as they relate to all methods of abortions. In fact, I would happy to voir dire on her research particularly related—

THE COURT: No. I think that is actually satisfactory.

Her objection was the same as with regard to Dr. Sprang, with regard to her testifying as an expert on intact D&E. My ruling would be the same, unless you have some compelling reason why I should change my ruling with respect to this doctor.

MS. CLARK: I think the ruling is consistent with Dr. Sprang's ruling.

THE COURT: All right. Then, the doctor will be—Dr. Shadigian?

THE WITNESS: Shadigian, that's right.

THE COURT: —shall be qualified to testify as an expert in obstetrics and gynecology and on pregnancy termination with the exception of intact D&E and abortion [1219] complications.

She may, however, opine, obviously, as to the safety of the intact method and may testify as to what her understanding is. That testimony obviously will not be considered for the truth of the matter given that she has not observed, taught, or performed such procedure herself.

All right. You may continue.

[ELIZABETH SHADIGIAN, M.D.—DIRECT EXAMINATION RESUMED]

BY MS. CLARK:

Q. Dr. Shadigian, what do you understand the partial-birth abortion procedure to be?

A. In short, the partial-birth abortion procedure can be broken down into four separate parts. One is serial dilation of the cervix over two days to open the cervix or dilate it.

The second is the instrumental conversion of fetus or baby in a nonbreech presentation to a breech presentation.

And then, delivery of the baby up to the base of the skull.

And then, finally, placing, for example, scissors or other such instruments in the base of the skull and extracting the contents of the skull, and then delivering the rest of the baby.

Q. What materials have you reviewed that form the basis of your opinion that what you just described is a partial-birth abortion procedure?

[1220]

A. I've reviewed Dr. Haskell's initial report in 1992. I reviewed Dr. Paul's book, which describes both the Haskell cases as well as McMahon's cases. And then, I've also looked carefully at the ACOG document about D&X procedure.

Q. Do you understand the terms "D&X" and partial-birth abortion? Do you use those terms interchangeably?

A. I do, and I also include intact D&E with all the other definitions.

Q. Dr. Shadigian, is it your understanding that a D&X procedure would also be a surgical abortion in which the physician intentionally extracts a live fetus intact in a breech presentation until the head gets lodged at the women's internal cervical os, and then decompresses the head in order to vaginally deliver a dead fetus?

A. Yes.

Q. Doctor, can you briefly—what is your opinion as an expert in the field of obstetrics and gynecology about the medical necessity of a partial-birth abortion procedure?

A. I have never personally had to use a partial-birth abortion procedure to take care of women, even sick women with medical conditions.

I never seen any of my colleagues at the University of Michigan use it, nor have–I in medical school or residency ever seen this used to take care of even the sickest women.

Q. Dr. Shadigian, what is your opinion as an expert in the [1221] field of obstetrics and gynecology about whether the partial-birth abortion procedure offers safety advantages over other methods of abortion during the second-trimester of pregnancy?

A. The partial-birth abortion procedure has never been studied in a systematic way and reported in the literature in a peer-reviewed presentation nor in a peer-reviewed journal article. So, there is no sound basis to say there is anything safe about the D&X procedure, especially when there are other procedures, like the D&E procedure and the medical induction procedure that are safe and well-studied in the medical literature.

Q. Is there anything in your training and experience that you found particularly useful in evaluating the medical necessity of the partial-birth abortion procedure?

A. Well, I did perform both a domestic and international literature search just because I wasn't sure if there were articles that had been published or not. And so up through the beginning of January 2004, I

performed a full literature search, and I had specialized librarians help me to make sure I didn't miss any keywords. So because I actually have done that myself I feel confident saying there hadn't been any published data on the D&X procedure.

Q. And is there anything with respect to your training or clinical experience that helps you form your opinion?

* * * * *

[1229] our first choice.

Q. And why do you offer medical induction as the first choice at 20 weeks or later?

A. Just because the safety data is so much better at 20 weeks and greater, especially now that we use almost exclusively misoprostol for inductions, although not exclusively.

Q. Do you continue to treat your patients after they have had a termination for a fetal anomaly?

A. I make it really clear to women that I am their doctor, whether they choose to have an abortion for either fetal anomalies or electively or for whatever reason; that I want to continue to be their doctor afterwards. And I have done that on many occasions.

Q. Have you delivered babies for some of your patients after they have had a termination for maternal complication or because of a fetal anomaly?

A. Yes, I have.

Q. Doctor, in your opinion, is the D&X procedure ever necessary to terminate a pregnancy in which there is a fetal anomaly?

A. No.

Q. Why not?

A. There are just other better methods, both the D&E disarticulation method as well as medical induction have safety data that we know about from many different sources, from many [1230] different institutions, both nationally, internationally, so that we have some basis to talk about safety when we talk about those two procedures.

Q. In your experience in treating patients with fetal anomalies, is there anything unique about the fetal anomalies that you have seen that would require an intact extraction as performed in the D&X procedure as you understand that procedure?

A. No, I have not.

Q. Have you ever had a patient with the fetal anomaly of conjoined twins?

A. Yes, I have.

Q. What happened with that patient?

A. This was a patient of mine who I had helped with her first pregnancy, and this was a second pregnancy. And she was diagnosed on her routine ultrasound of having two babies, and two babies connected at both the thorax or upper chest and lower abdomen. So there were two babies, two heads, two sets of shoulders, et cetera.

And so, we talked in the office right afterwards, that this, because of the kind of anomaly it was, wasn't something that could be fixed because of how complicated the heart defect was. And it wasn't something that you could just separate the babies and they would be fine later; you know, that it probably was a lethal anomaly for the babies.

* * * * *

[1233] D&X procedure is a different procedure than the D&E procedure, and that it dilates the cervix more. That it is usually performed later in a pregnancy, and that it involves a nonphysiologic pulling the baby through the cervical os and then explaining the whole procedure in terms of what happens with the baby's head, et cetera, so that they could be truly informed of what it is.

Q. In your medical opinion, is it sound for physicians to rely on their own experience in performing the D&X in deciding to perform a D&X on a patient?

A. No.

Q. Doctor, the court has heard physicians testify who have performed D&X procedures and who performed some variation of the D&X procedure. They have testified that the procedure is safe, based on experience.

What is your opinion with respect to the assertions that the D&X procedure is intuitively safe based on clinical experiences with that procedure?

A. Well, I believe that those abortion providers are telling the truth; that they believe that the D&X is just as safe as a D&E disarticulation procedure. But it is really based on anecdote. It's just based on doing this procedure at the same time on different patients. So that it can be considered sort of like a case, but it can't be considered long-term safety data. It can't be [1234] considered short-term safety data, especially because most abortion providers never see their patients back after the abortion procedure.

MS. KRASNOFF: Objection, Your Honor, foundation.

THE COURT: Sustained.

MS. CLARK: Is it sustained on a patient—I mean, they never see them back, though, that part of the foundation?

THE COURT: The first part of the question.

BY MS. CLARK:

Q. Doctor, you testified that many patients don't go back to the doctor for whom they receive abortion follow-up care; is that correct? Or something to that—

MS. KRASNOFF: I believe that was stricken based on the objection.

THE COURT: The objection was sustained. You need to establish a foundation that she has that knowledge.

BY MS. CLARK:

Q. Doctor, do you have an opinion as to whether or not patients frequently return to their physician who performed the abortion for follow-up care? Just do you have an opinion?

A. Yes, I do have an opinion.

Q. What is that opinion based on?

A. The opinion is based on two things: one, my own patients who have received abortions from different providers, and second from medical research.

* * * * *

[1269] fact, terminate the pregnancy?

A. Well, what we try to do is look at the evidence and studies. So what we try to do is look at, you know, D&E procedure at different gestational ages and medical induction procedure at different gestational ages, and see if we can draw some kind of conclusions from actual studies. Not just at U of M, but people's studies across the country and across the world, so that we can look at data and know that we are offering our patients the best medical care possible and try to reduce the amount of morbidity and mortality that a woman makes during this from the choices around induction or D&E procedure.

MS. CLARK: Your honor, may I approach?

THE COURT: Yes.

BY MS. CLARK:

Q. Doctor, I have just shown you what has been identified as Defendant's Exhibit LT A-15. Have you seen this article before?

A. Yes, I have.

Q. And does this article support your opinion in any way about the safety of induction at the later stages in the—of the second-trimester of pregnancy?

A. Yes, it does.

Q. I direct you to table number 4, which is on page 727.

Does this table support your opinions in any way?

A. Yes. This table looks at D&E, or dilation and evacuation, [1270] procedure versus labor induction. And it shows that labor induction is safer at 21 weeks

and greater. And this is using even the old instillation methods, not the more modern misoprostol.

Q. What is the significance of using the early methods as opposed to the misoprostol drug used with labor induction?

A. Well, the newer studies have shown misoprostol is, in fact, even safer than old instillation methods. So that we can safely assume that if this is done with misoprostol modernly, we would have even lower rates of mortality for women at 21 weeks and greater.

Q. And this data, what year was this data based upon?

A. This was based on early data from 1972 to 1987.

Q. If you look at table 4, I think it—I will just leave that.

Now, doctor, are there other studies or articles that you have relied upon in forming your opinion that induction is as safe or safer than the D&E procedure at certain stages in the second-trimester of pregnancy?

A. Yes.

Q. And are those the Grimes studies?

A. Yes.

MS. CLARK: Your Honor, may I approach?

THE COURT: Yes.

BY MS. CLARK:

[1271]

Q. Dr. Shadigian, I have handed you what has been marked as Defendants Exhibit LT A-25. Is this one of the Grimes studies you were referring to?

A. Yes, it is.

Q. What year was this study published?

A. This study was published in 1985.

Q. If I could have you return to page 93. And in the second full paragraph, the paragraph begins:

"The greater comparatives."

A. Yes.

Q. If you read that second sentence in that paragraph, would you read that second sentence out loud?

A. Certainly. "At greater than or equal to 16 weeks gestation the risks of death from D&E and from instillation abortion are—similar and statistically indistinguishable."

Q. And does this sentence support your opinion about the relative safety of D&E and induction?

A. Yes, it does.

Q. And does the change in the use of misoprostol affect the study in any way, do you think, with respect to induction procedure?

A. Well, just with the newer misoprostol, in fact, it has been shown it is even safer than instillation methods, so we should [1272] find that mortality is lower with modern use of prostaglandins, as compared to D&E.

Q. Now, what is your basis for your opinion that misoprostol has improved the method of induction?

A. There are several articles and several studies that have been performed around the world that are how I base my opinion about misoprostol.

MS. CLARK: May I approach the witness?

THE COURT: Yes.

BY MS. CLARK:

Q. This is Defendant's LT A-27.

Dr. Shadigian, I have handed you what has been identified as Defendant's Exhibit LT A-27.

A. Yes, I have it.

Q. If you would look at the first column, turning to the second paragraph where it begins:

"The details of the beneficial effects."

Do you see that?

A. Yes.

Q. Would you read out loud the second sentence in that paragraph, beginning with "however"?

A. "However, for one specification indication, cervical ripening as a prelude to induction of labor, misoprostol has been used so frequently and effectively that it has become the treatment of [1273] choice."

Q. Would you agree with that statement?

A. Yes, I do.

Q. If you turn to the next page, the left-hand column, at the very bottom the sentence beginning:

"Yet we reaffirm." Would you begin with "we reaffirm," and read that sentence?

A. "We reaffirm that misoprostol is a safe and effective drug for cervical ripening and induction of labor when used appropriately."

Q. And do you agree with that statement?

A. Yes, I do.

MS. CLARK: May I approach?

THE COURT: Yes.

BY MS. CLARK:

Q. I am handing you what has been identified as Plaintiffs' 31. I would like you to turn to page 142, please. And the "Abortion by Labor Induction" chapter.

If you look under the section "Morbidity and Mortality," in that first paragraph, would you read out loud the very last sentence?

A. Starting with "although"?

Q. Oh, I am sorry. No. Starting with—we're on page 142, under "Morbidity and Mortality," the first full paragraph. The sentence that begins: [1274]

"An increase use, increased use of vaginal prostaglandins."

A. Okay. "Increased use of vaginal prostaglandins. Improvements in technique and better cervical preparation have probably reduced mortality from induction abortions."

Q. And do you agree with that sentence?

A. Yes, I do.

Q. Do you understand that sentence to refer to improving it from the instillation method of induction?

A. Yes. They have tables about instillation methods on the same page, even.

Q. And is misoprostol a prostaglandin?

A. Yes, it is.

Q. Do you know if other physicians besides yourself are using misoprostol in connection with the induction method of pregnancy termination?

A. Yes, I do.

Q. How do you know that?

A. Because I practice at U of M, and I have to take over after they have started an induction, and I know what techniques they are using.

In addition, we have a web site where we have different protocols. And one of the protocols is about misoprostol.

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[CROSS-EXAMINATION BY MS. KRASNOFF]

[1283]

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Q. And you would agree, would you not, if there were two women at 20 weeks gestational age, both are going to have D&E abortions, and both get the same doses of misoprostol and the same number of laminaria, you will not necessarily get the same amount of dilation in each of those two women; is that correct?

A. Yes.

Q. Now, you agree, would you not, that in performing a D&E the physician may apply traction to the fetal part that he or she is grasping and be able to pull it through the cervical os?

A. Yes, that can be done.

Q. And if that happens, the part that has been brought through the cervix may disarticulate at the internal cervical os due to the traction; is that correct?

A. Yes, it may.

Q. But you agree it is possible in that situation if there is adequate dilation that the physician would be able to extract the fetus up to the torso; is that correct?

A. Possibly.

Q. And if that happened and you were supervising a resident in a D&E, you would tell them to disarticulate, would you not?

A. Yes.

Q. And if the fetus were alive at the point it emerged up to the torso that disarticulation would be a legal act, would it [1284] not?

A. I wouldn't be performing that procedure if it was a live baby.

Q. Well, can you offer an opinion if another physician were performing that and that situation presented itself where the fetus had emerged in a D&E up to the torso, and then the physician disarticulated, would that be a lethal act?

A. It could be, but it wouldn't necessarily be.

Q. And when would it not be?

A. Well, disarticulation takes several passes, so it is not when you just twist a foot off that the baby is going to die immediately. In fact, it is going to hemorrhage over a period of time. So it will depend on how many other passes you take and disarticulation moves you do.

Q. Well, in this example, it had been removed all the way to the torso. Could you disarticulate at the torso and have the fetus survive?

A. Not for many minutes.

Q. You testified earlier you've only performed D&E 's on demised fetuses; that's correct?

A. Yes, that is correct.

Q. And sometimes those fetuses have been demised for a day or two; is that right?

A. Yes.

Q. I think you mentioned this, but the friability of the fetus [1285] is effected by fetal demise such that it breaks apart more readily when there has been fetal demise; is that correct?

A. Yes, compared to live babies.

Q. And you would agree, would you not, that there is always a risk of damage to the cervix or to the uterus whenever instruments are passed into the uterus?

A. Yes.

Q. It is true that one risk of D&E is that fetal bones may be exposed which presents a risk of puncturing or lacerating the uterus; is that correct?

A. Yes.

Q. And you would agree that removal of the fetus intact during a surgical abortion would reduce that risk, wouldn't it?

A. Yes.

Q. And now I am going to switch gears a bit and talk in general about inductions.

I believe you have talked about two different kinds of inducing agents today, oxytocin or pitocin and prostaglandins, such as misoprostol; is that correct?

A. Yes.

Q. It's possible with oxytocin that the woman can have too many uterine contractions or tetany; is that right?

A. Yes.

Q. And tetany can result in uterine rupture; is that correct?

A. Yes.

[1286]

Q. And you would agree that oxytocin may be contraindicated or at least relatively contraindicated if a women has a previously scarred uterus, would you not?

A. I would say relatively, but not absolutely.

Q. And that would especially be the case if the scar is what is known as a vertical or classical cesarean section scar; is that right?

A. Yes, it could be.

Q. And prostaglandins, like misoprostol, are also contraindicated for a woman who has a prior cesarean section; are they not?

A. Not absolutely, but that is our general practice not to use them.

Q. And you would agree that an induction may not be advisable for some women with serious medical conditions such as a serious heart condition, because the contractions could compromise her cardiopulmonary situation; is that right?

A. That is possible.

Q. And some women may have an allergy to the medicines that are used in induction making that method not appropriate for them; is that correct?

A. Yes.

Q. So, you would agree with me, then, that there may be situations where an induction would not be the optimal form of abortion for a woman?

[1287]

A. There could be.

Q. And you would agree there are certain risks associated with induction; is that right?

A. Yes.

Q. And those include, I believe, chorioamnionitis or infection?

A. Yes.

Q. Excessive blood loss from hemorrhaging?

A. Yes.

Q. And potential rupture of the uterus?

A. Yes.

Q. Inductions are inpatient procedures, aren't they?

A. Yes.

Q. That means they are performed in hospitals, right?

A. Yes.

Q. And the woman is in the hospital the entire time of the procedure; is that right?

A. Yes.

Q. And I think you testified earlier that the average length of time using the medications that you use is—for an induction is between four and 24 hours; is that correct?

A. Yes.

Q. But in your experience an induction has taken as long as two-and-a-half days; is that correct?

A. Yes.

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[1294]

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Q. If there are two abortion methods, one was a nondestructive method that had greater health risks, and one was a destructive method that is safer—

A. Okay.

Q. —would you support requiring a woman to have the less safe method prior to fetal viability?

A. No.

Q. And you yourself do not take care of some of the most sick pregnant women at the University of Michigan; is that right?

A. I take care of some of them, but not all of them.

Q. Some of them are taken care of by the maternal fetal medicine specialist; is that right?

A. Yes.

Q. And you are not trained in maternal fetal medicine; is that right?

A. Yes.

Q. And, Dr. Shadigian, who is the chair of your department at the University of Michigan?

A. His name is Dr. Timothy R.B. Johnson.

Q. And he is a specialist in maternal fetal medicine; is he not?

A. Yes, he is.

[1295]

Q. And you respect Dr. Johnson as a physician, don't you?

A. Yes, I do.

Q. And you are also aware that Dr. Johnson is a plaintiff in the case pending in New York which challenges the Partial-Birth Abortion Ban Act of 2003, are you not?

A. I am aware of that.

Q. In fact, you have reviewed his expert report, have you not?

A. I believe I have reviewed portions of it.

Q. Well, I am going to show you your deposition, if that is okay with you. Could I ask you to turn to page 68?

MS. CLARK: I am sorry. What page?

MS. KRASNOFF: Sixty-eight. And I believe it is lines—I am on the wrong page—16 to 17.

BY MS. KRASNOFF:

Q. Does that refresh your recollection whether or not you have reviewed Dr. Johnson's expert report in the New York case?

A. I didn't know I needed refreshing. I don't understand the question.

Q. The question that was asked you at the deposition:

> "Have you reviewed Dr. Johnson's expert report?"

And your response was:

> "Yes."

Today you said you only reviewed parts of it. Have you reviewed it all?

[1296]

A. I can't recall how much of which report I've reviewed how much of. I have looked at so many reports. I am sure I reviewed his report. I don't know if I read every "a" and "the," but I reviewed it.

Q. Okay. And are you aware, based on that review, that it's Dr. Johnson's removed?

BY MS. KRASNOFF:

Q. Are you aware based on your review of that report that it is Dr. Johnson's opinion that intact removal of a fetus during a D&E may be safest and most appropriate for terminating a pregnancy for some women?

A. I guess before I would agree to that I would like to see it, because I assume you are reading it from his report, but I don't know that.

Q. Well—

A. I can't remember what he said, exactly.

Q. —if you look at page 172 of your deposition, lines four through eight.

A. Okay.

Q. You were asked:

> "Do you understand that it is his opinion that in some circumstances D&X may be the safest and most appropriate method for terminating a pregnancy?"
>
> And you answered:

[1297]

> "If that is in his report, I did read that."

A. Yes. I still stand behind that. I think I was getting confused between "deposition" and "report," because his deposition is very long.

Q. Yes. And I only asked about his report—

A. Yes.

Q. — which was prior, I believe, to your—

A. Right. That is why I was confused. Thank you.

Q. So you have reviewed the report—

A. Yes. Yes. I certainly have.

Q. —which, unfortunately, I don't have to show you today.

So given Dr. Johnson's participation in New York, you would agree that responsible physicians could reach different conclusions as to the medical appropriateness of banning the procedures covered by the Partial-Birth Abortion Ban Act of 2003; is that true?

A. Yes.

Q. You would also agree there is no consensus in the medical community that the procedures banned by the Partial-Birth Abortion Ban Act of 2003 are not safer for some women in some circumstances than other available procedures?

A. The opinion is diverse.

Q. So there is no consensus?

A. Yes.

* * * * *

[1299]

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Q. We discussed an article by Dan Epner, entitled "Late Term Abortion," which was published in a Journal of the American Medical Association in August of 1998.

Do you have that handy up there?

A. Yes.

Q. That article states, in part, quote:

"Intact D&X may minimize trauma to the woman's uterus, cervix and other vital organs."

You agree with that statement, don't you?

A. Yes, it may.

* * * * *

[1303]

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Q. And your conclusion that induction is safer is because you believe after 20 weeks induction is safer than D&E; is that right?

A. Mine is based on medical literature, my opinion.

Q. And the medical literature that is available is about D&E; is that right?

A. Yes, it is.

Q. So, it's fair to say that your conclusion that induction is safer is because you believe that after 20 weeks D&E is safer than induction; is that correct?

A. No.

Q. Why not?

A. You said it backwards.

Q. Oh, because I said it backwards? Let's try it again, then.

Is it fair to say that your conclusion that induction is safer is because that you believe after 20 weeks induction is safer than D&E abortions; is that correct?

A. Yes.

Q. In fact, you don't find intact D&E any more objectionable [1304] than D&E, do you?

A. What do you mean by "objectionable"?

Q. If you could please turn to your deposition, page 242, lines 18 to 20.

You were asked:

"Do you find D&X or partial-birth abortions more objectionable than D&E ?"

And you responded:

"No."

A. Yes. I did say that.

Q. Do you believe that?

A. Yes.

* * * * *

[1321]

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Q. Dr. Shadigian, you, yourself, will only perform an abortion if the woman is so sick that the only way she is going to survive is to have the pregnancy ended; is that correct?

A. If you mean abortion on a live infant, yes.

Q. Yes, I do mean on a live fetus.

Is that correct?

A. Yes.

Q. And you would agree, would you not, that any physician can't know 100 percent if someone is going to die or not when faced with a very sick pregnant woman; is that correct?

A. That's correct.

[1322]

Q. You would agree that the decision of whether there is a threat to the woman's life must be left to the physician's best medical judgment; is that correct?

A. Yes.

Q. You agree, don't you, that the safest and most appropriate abortion procedure for a particular woman depends in part on the gestational age of the fetus at the time of the abortion; is that correct?

A. Yes.

Q. And you agree, don't you, that the safest and most appropriate abortion procedure for a particular woman depends in part on that woman's health at the time of the abortion?

A. Yes.

Q. And you agree that the safest and most appropriate abortion procedure for a particular woman depends in part on any medical contraindications she might have to a particular procedure or part of a procedure?

A. Yes.

Q. And you agree that the safest and most appropriate abortion procedure for a particular woman depends in part on her prior history of gynecologic surgery?

A. Yes.

Q. And you agree that the safest and most appropriate abortion procedure for a particular woman depends in part on the training, skill, and experience of the physician performing the [1323] abortion?

A. Yes.

Q. And you agree, don't you, that even if two abortion procedures are similar in terms of statistical risks, which procedure will, in fact, be safer for any particular woman depends on her individual circumstances?

A. Yes.

Q. Dr. Shadigian, this is not the first time you've testified in support of a law that regulates abortion, is it?

A. No.

Q. In fact, you have offered sworn testimony of some sort and support of a variety of state laws that relate to abortion, haven't you?

A. I have testified one time in Alaska.

Q. You've offered declarations as well?

A. Expert reports, yes.

Q. And those are sworn statements?

A. Yes.

Q. And you have given deposition testimony as well?

A. Yes.

Q. And that was under oath?

A. Yes.

Q. And so you have offered sworn testimony in support of an Alaska law requiring a minor to obtain parental consent before an abortion; is that correct?

[1324]

A. Yes.

Q. You've offered sworn testimony in support of laws that require mandatory delay before a woman can have an abortion in Indiana, Alabama, and Ohio; is that correct?

A. Yes.

Q. And you testified in favor of a Florida law that required a woman to receive certain state-mandated information before she could have an abortion; is that correct?

A. Yes.

Q. And you've uniformly offered your opinion in support of those laws?

A. In those particular circumstances, I did. Yes.

Q. In addition to the cases we just discussed, you've also offered your opinion in a case brought against Planned Parenthood Federation of America, who is a plaintiff in this case, trying to force Planned Parenthood to inform women seeking abortions that abortion increases the risk of breast cancer; is that correct?

A. Yes.

Q. Are you aware that both the trial court and the court of appeals dismissed that case?

A. If you tell me they did, I am sure they did.

* * * * *

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C 03-4872 PJH

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. AND PLANNED PARENTHOOD GOLDEN GATE, PLAINTIFFS

v.

JOHN ASHCROFT, ATTORNEY GENERAL OF THE UNITED STATES, DEFENDANT

TRANSCRIPT OF PROCEEDINGS
Tuesday, Apr. 13, 2004
Volume 9

BEFORE THE HONORABLE
PHYLLIS J. HAMILTON, JUDGE

APPEARANCES:

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* * * * *

[1345]

[CURTIS COOK, M.D.—DIRECT EXAMINATION]

THE COURT: All right. Good morning. Are you ready with your next witness?

MR. SIMPSON: Yes, Your Honor.

MS. CLARK: Defense calls Dr. Curtis Cook.

THE CLERK: Please raise your right hand.

Dr. Curtis Cook, called as a witness for the defendant, having been duly sworn, testified as follows:

THE WITNESS: I do.

THE CLERK: Please take the stand.

Please state your name for the Court.

THE WITNESS: My name is Dr. Curtis Cook.

THE CLERK: Spell your last name.

THE WITNESS: C-o-o-k.

[DIRECT EXAMINATION]

BY MS. CLARK:

Q. Good morning, Dr. Cook.

A. Good morning.

Q. Would you please tell the Court what you do for a living?

A. I am a maternal fetal medicine specialist, meaning that I take care of complicated pregnancies, generally complicated by either maternal medical conditions, fetal abnormalities or [1346] obstetrical complications that develop during the course of the pregnancy.

Q. And where do you work?

A. I work in Grand Rapids, Michigan.

Q. At what hospital?

A. I'm based at Spectrum Health in Grand Rapids, but we cover a number of hospitals in the West Michigan area.

MS. CLARK: May I approach, Your Honor?

THE COURT: Yes.

BY MS. CLARK:

Q. I am showing you what has been identified as Defendant's A-4. Is this a copy of your curriculum vitae?

A. It is.

Q. Did you create it?

A. I did.

Q. Does that accurately reflect your education, work experience and publications?

A. I believe that it does.

MS. CLARK: The Government moves to admit into evidence Defendant's Exhibit A-4.

THE COURT: Any objection?

MS. GARTNER: No objection, Your Honor.

THE COURT: Admitted.

THE CLERK: A-4 into evidence.

MS. CLARK: Thank you.

[1347]

(Defendant's Exhibit A-4 was received in evidence.)

BY MS. CLARK:

Q. Dr. Cook, are you board certified in OB/GYN?

A. I am.

Q. Are you board certified in maternal fetal medicine?

A. I am.

Q. And can you explain a little bit more, what is maternal fetal medicine?

A. Well, maternal fetal medicine is a subspecialty area of interest. After completion of obstetrics and gynecology training, you can elect to do further training in a subspecialty area of obstetrics and gynecology.

You can train in the area of female cancers, in the area of infertility or in the area of complicated pregnancies. And generally, that entails another three years of training beyond your residency program to complete that requirement.

Q And what courses of instruction do you go through to become a maternal fetal medicine specialist?

A. During the course of that training you are dealing with the most complicated obstetrical cases. Again, those are complicated by either preexisting maternal conditions which entail a variety of diseases and pathologies, fetal conditions which can entail a number of structural abnormalities or genetic or chromosomal abnormalities, and, then, obstetrical [1348] complications that develop during the course of the pregnancy.

As a result of those complications, you have to learn how to care for women throughout the entire pregnancy, which sometimes entails having to deliver the baby prematurely or end or terminate the pregnancy for the benefit of the mother. And, additionally, it generally includes training in fetal surgery and fetal therapies, as well.

Q. Have you had training in abortion techniques?

A. I have.

Q. What kinds of techniques?

A. We have been trained to find ways to evacuate the uterus in all three trimesters using combinations of medical and surgical approaches.

Q. And what are some of those kinds of surgical approaches that you have been trained in?

A. Well, they include suction evacuation, sharp curettage, dilatation and evacuation, induction of labor with medications, hysterectomy or cesarean delivery.

Q. After you finished your fellowship in maternal fetal medicine, where did you go on to become employed?

A. After I completed my fellowship training I returned to Grand Rapids in West Michigan where I had done my obstetrics and gynecology training and started working there as a maternal fetal medicine specialist.

Q. When did you become employed at Spectrum Health Hospital?

[1349]

A. In 1995.

Q. What do you do at Spectrum Health Hospital?

A. Well, I have various roles and functions, but I serve as the Associate Director for Maternal Fetal Medicine. I also have a teaching appointment with Michigan State University. And previously I helped administer our obstetrics and gynecology residency training program.

We also have teaching positions in two other residency programs in West Michigan, and we serve on the staff of multiple other hospitals in West Michigan.

Q. And as Associate Director of Maternal Fetal Medicine at Spectrum Health, what does that job responsibility entail?

A. Well, there are several areas of responsibility. Obviously, one is just the clinical management of complicated pregnancies. That includes serving a very wide rural area, basically all of western and northern Michigan, where we not only take care of patients referred from that area, but we are also responsible to going out and lecturing and educating physicians in that region about the management of complicated pregnancies.

We also train and supervise the training of our residents in complicated pregnancies, as well as Michigan State medical students.

Then, there are some research and administrative responsibilities, as well.

[1350]

Q. Do you hold a specific position at Michigan State University?

A. Yes, I am an Associate Clinical Professor in the Department of Obstetrics and Gynecology.

Q. And what are your duties, specifically, in that position?

A. Predominantly, the clinical training of medical students from Michigan State, mostly during their third-year obstetrics and gynecology clerkships; occasionally during their fourth-year electives.

We also have some formal lectures that we give that the medical students attend, as well.

Q. Do you teach either residents or medical students about pregnancy terminations in all three trimesters of pregnancy?

A. We do train them how to evacuate the uterus in all three trimesters. Sometimes that involves medical students. Generally, it involves predominantly our medical residents.

Q. Doctor, what kinds of medical conditions in pregnancy do you provide care for, including conditions existing before pregnancy and conditions existing after pregnancy?

A. Well, in the area of just maternal medical conditions, the preexisting conditions can be a host of medical conditions involving one or multiple organ systems.

So it can include central nervous system abnormalities for the mother, cardiovascular problems, pulmonary problems, renal problems, hepatic problems or liver [1351] problems. So a number of preexisting medical conditions there. It can include malignancies. It can include blunt or penetrating trauma to a pregnant woman. It can also include developed—problems that develop during the course of the pregnancy, like heavy bleeding, severe infection, other surgical complications that arise from attempted procedures during pregnancy.

And it can also include the development of obstetrical complications that are unique to pregnancy, like preeclampsia or high blood pressure problems during pregnancy and gestational diabetes, multiple gestation. It can include a whole host of complications.

Q. And what kinds of fetal conditions in pregnancy do you care for?

A. Again, we care for a whole variety of fetal complications that generally can be categorized as genetic or chromosomal abnormalities where a baby has inherited a genetic abnormality or has an abnormal number of chromosomes present. Or generally in the category of structural abnormalities where a baby may have one or multiple organ systems involved.

And then, there are several unique type fetal conditions that we care for, like multiple gestation, conjoined twins, twin-to-twin transfusion, and other sort of unique fetal conditions in pregnancy.

Q. In your practice, do you perform medical procedures on [1352] living fetuses?

A. We do.

Q. Can you describe some of the circumstances in which you perform procedures on living fetuses?

A. We perform a number of medical and surgical procedures on the fetus while it is still inside the womb. This can include trying to correct abnormal fetal heart rate rhythms or heart rhythms.

It can include trying to correct severe fetal anemia. It can include trying to bypass certain structural obstructions in the baby's system, such as the urinary system.

It can include decompressing abnormal fluid collections in portions of the baby.

It can include biopsies or other samplings. So there is a number of different therapies that are developed in the area of fetal surgery or fetal medications.

Q. Are any of these procedures life-saving procedures for the fetus?

A. Most of the ones that we do are, because there are risks associated with doing intrauterine procedures, so generally there has to be a significant benefit in order to accept that level of risk.

Q. Do you also deliver babies?

A. We do.

Q. How many babies do you deliver in an average year?

[1353]

A. On an average year I probably deliver somewhere in the order of 100 to 200 babies.

Q. Is it fair to say that you are delivering babies in the context of high-risk pregnancies?

A. Yes, that would be a fair statement.

Q. Do you receive referrals from OB/GYN's of patients with complicated pregnancies?

A. Yes. Virtually every patient we see is referred from another physician. Sometimes those are nonOB/GYN physicians. But the majority do come from obstetricians and gynecologists.

Q. Why is that the case?

A. It is because they have developed a problem either maternal or fetal that is beyond their level of training or their experience or their comfort level.

Q. What is the gestational age for pregnancies that you typically are involved with?

A. Most often we see patients in the mid-trimester or later, if it is a fetal condition. For maternal conditions, we sometimes see them very early on, such as

diabetics. But certain maternal conditions like pre-eclampsia are late-pregnancy phenomena.

So we get referred patients in all three trimesters that you can generally group, depending on the kind of problem that they develop.

Q. Doctor, you do not perform abortions for elective reasons; [1354] is that right?

A. That is correct. I do not.

Q. Even though you do not perform elective abortions, does your practice require that you have expertise in the safe and effective methods for terminating pregnancy?

A. Yes, because there are times when emptying the uterus or terminating the pregnancy is necessary for the benefit of the mother, so you do need to be familiar with those techniques, and I am.

Q. Doctor, does your practice also require that you may have to end a pregnancy prematurely such that the fetus is likely to die from terminating the pregnancy?

A. I am sorry. Could I have you restate the question?

Q. Does your practice require that you may have to end the pregnancy early such that the fetus is likely to die from that premature termination of the pregnancy?

A. Yes, that is the case at times.

Q. Can you be a maternal fetal medicine specialist without knowing how to end a pregnancy early?

A. I don't believe that you can just because you are dealing exclusively with complicated pregnancies.

Q. Do you, as a maternal fetal medicine specialist, have to have a full understanding of the methods to evacuate the uterus in all three trimesters?

A. I believe that you do.

[1355]

Q. Why is that?

A. Well, again, because the problems that arise in a maternal fetal medicine practice, especially one of our scope and volume, entails finding women that have significant problems in all three trimesters. And sometimes the only correct management in those situations is ending the pregnancy such that the woman can start recovering from the complications that pregnancy poses to their health.

Q. Dr. Cook, does your specific practice involve pregnancy termination?

A. It does.

Q. Have you ever had to terminate a pregnancy when the fetus is still living?

A. I have.

Q. Could you describe to the court the circumstances in which you have had to terminate a pregnancy both previability and postviability?

A. Well, the previability line continues to shift to earlier gestational ages, and currently is approximately 23 weeks gestation. So, the times that we have to terminate a pregnancy prior to 23 weeks has become less and less than it was when viability was 25 weeks or 28 weeks.

But still, probably about 10 percent of the time are women that we care for develop a problem that is

either significantly worsening or nonresponsive to our therapies that [1356] require us to deliver her prematurely, sometimes even prior to 23 weeks.

In our practice, that most commonly results from women that develop very severe hypertensive complications or severe infectious or bleeding complications.

Q. Are there any differences, for example, the doses of medicine in which—in the way in which you perform a termination when the fetus is previable versus postviable?

A. Yes. When we are talking about an infant that is 23 weeks or greater, then there is obviously a fetal interest at play, as well. And we are maternal fetal medicine specialists, so we have at least two patients in any given pregnancy, and sometimes more with multiple gestation.

So we try to effect the delivery in the manner that is safest for the mother, yet still retains the best possibility for a good outcome of survival for the fetus if we are doing it at 23 weeks or later.

If we are doing it less than 23 weeks, obviously the fetal interests have less of a concern, so we might use different types of medications or higher doses of medications or less monitoring of the fetal condition.

There are a number of adjustments we might make in that scenario.

Q. When you are terminating a pregnancy previability, what is your primary concern in performing that termination?

[1357]

A. Our primary concern is trying to find the safest and most expeditious manner to separate the mother from the fetus and the placenta from the mother in order to continue the healing process or recovered process from the pregnancy.

Q. Doctor, what is the most common method of pregnancy termination you currently utilize?

A. Well, in our practice because most of these conditions develop later in gestational ages, our predominant method is medical induction of labor, which offers us multiple other benefits that are somewhat unique to our setting in that it allows us an intact fetus for pathologic evaluation. Allows us to deliver the mother in most safest, most natural or physiologic way in women that typically have significant other medical conditions. And it also allows us to monitor the mothers in the safest manner.

Q. Doctor, how do you perform the induction method of termination?

A. Most often we use prostaglandin, such as misoprostol or prostaglandin E1 suppositories.

Q. How do you administer those prostaglandins?

A. Typically, we administer them as vaginal suppositories.

Q. Do you ever use the instillation method?

A. We do not.

Q. Have you ever had to perform an induction on a living fetus?

[1358]

A. I have.

Q. Does the fetus ever die in the processes of the induction procedure?

A. It does.

Q. How often do you perform induction, both previability and postviability?

A. Well, postviability it is a very regular part of our practice and probably a weekly phenomena when a woman develops a condition whereby we think it is in her best interest to deliver prematurely, meaning less than 37 weeks gestation, but after 23 weeks gestation.

As far as the number that we do prior to 23 weeks gestation, that is a much lesser phenomena, even in our practice. And that may occur one or two times a month.

Q. Why is induction the predominant method of pregnancy termination that you utilize in your practice?

A. Again, it's sort of related to three basic phenomena. One is the gestational age with which we are usually working with, which is usually more than 20 weeks gestation. Also, it has to do with the preexisting maternal medical conditions where we want to try to avoid some of the complications that surgery would pose. So we would prefer a medical or a variation of a normal labor process.

The third would be being able to maximize our ability to evaluate the intact fetus, including an intact [1359] central nervous system after delivery.

There are also some benefits in being able to monitor her labor more accurately when she can

continue to give us feedback about symptoms. We can utilize certain other types of higher technology monitoring during the course of those labor processes.

Q. Between what gestational ages do you perform the induction method of pregnancy termination?

A. Basically, anywhere from 16 weeks until term.

Q. Is it fair to say that you do not oppose having to act to protect women from a serious medical condition even if that means a living fetus might die?

A. I am sorry. Could I have you repeat that one more time?

Q. Is it fair to say that you do not oppose having to act to protect women from a serious medical condition, maternal medical condition, even if that means a living fetus might die?

A. Yes, that is a true statement. We would never sacrifice a mother in order to try to save a fetus, although frequently we don't have to make that choice. Oftentimes, we can support a mother to the point at which her baby has a chance for survival, as well, without posing any increased or significant risk to her health or life.

Q. Have you had an occasion to perform an abortion by a method other than induction?

A. I have.

[1360]

Q. What methods?

A. Well, we have had situations where we have had to evacuate the uterus surgically on infants that no longer are living at that time or have failed other methods of attempted abortion.

We have also done it on situations where we have to use a surgical incision into the uterus, such as a c-section or hysterotomy.

We have also had some situations where we would have to do suction evacuations in unique situations because of pregnancy complications.

Q. Doctor, separate from the distinct methods of abortion that you have performed, have you in your practice ever had to perform an internal podalic version on the fetus?

A. Yes. In the situation of multiple gestations, most often a twin pregnancy where the first child has already delivered and the second child is lying in a transverse position, we will oftentimes have to reach in and turn the baby to a feet first position in order to facilitate the delivery.

Q. Doctor, in your practice have you used osmotic dilators?

A. I have.

Q. In what context?

A. Well, in the days prior to some of the newer prostaglandin formulations, medical inductions were more often done with other types of medications, such as oxytocin or pitocin. In those situations we would frequently try to prepare the cervix [1361] preinduction by placing laminaria into the cervix the day prior to the induction.

Q. Turning to your professional organizations that you belong to, do you belong to any professional organizations?

A. I do.

Q. What are some of those organizations?

A. The American Medical Association, the American College of Obstetricians and Gynecologists, the Society of Maternal Fetal Medicine, Michigan State Medical Society, Christian Medical and Dental Association. There is a number.

Q. You are a co-founder of Physicians' Ad Hoc Committee for Truth?

A. That is correct.

Q. What is or was that group?

A. That was an ad hoc group or an ad hoc committee that eventually grew to over 400 physician educators in the area of complicated pregnancies and pediatric management thereafter who got together specifically for the purpose of trying to correct a lot of the medical misinformation that initially was being circulated regarding this particular procedure.

So the group's focus was solely on trying to provide medical—accurate medical background, position papers on specific details of this procedure. We never addressed other abortion procedures. We never addressed other ethical issues related to life issues, such as embryonic stem cell research or [1362] anything like that.

Q. And is "PHACT" the acronym, correct?

A. That is correct.

Q. Is that still in existence?

A. Well, I haven't been aware of any recent position papers or information that's been circulated from that organization for some time. Initially, there was a lot of activity as we tried to address each of the areas of

medical misinformation one at a time: Did the procedure even exist? How often did it happen? In what scenarios did it happen? Things of that nature. What the potential risks for the procedure were.

As I feel we were successful in sort of clarifying some of those issues, the group really doesn't have a purpose or a role at this point.

Q. Have you written any peer-reviewed articles published in the field of obstetrics and gynecology?

A. I have.

Q. And are those reflected in your C.V.?

A. I believe that they are. Yes. It seems to be fairly complete.

Q. Have you been an investigator in any randomized studies?

A. I have.

Q. Can you briefly describe your experience with being an investigator?

A. Well, research is often done in a collaborative fashion, so [1363] there are some randomized trials where I wrote the protocols, and I presented it to the institutional review board, and I initiated the study from the beginning.

There is others where I joined the process in progress. And there are some where we just became the local site for a multi-site study. So I have been involved in various different levels and various different forms of randomized controlled trials.

Q. Can you provide the court with one example of a randomized controlled study in which you were an investigator?

A. Yes. I am the principal investigator on an ongoing study that we have now that is an institution-specific study, meaning just our institution, looking at the issue of premature labor following early rupture of the membranes and comparing two different treatments for that phenomena to evaluate the eventual maternal and fetal outcomes.

MS. CLARK: Your Honor, defendant moves to qualify Dr. Cook as an expert in obstetrics, gynecology and pregnancy termination.

THE COURT: Any objection or request to voir dire?

MS. GARTNER: Yes, Your Honor. We would like to voir dire this witness.

THE COURT: All right.

MS. CLARK: We would also like to qualify him as an expert in maternal fetal medicine.

[1364]

THE COURT: All right. Thank you.

[CURTIS COOK, M.D.—VOIR DIRE EXAMINATION]

BY MS. GARTNER:

Q. Good morning, Dr. Cook.

A. Good morning.

Q. Sorry. My name is Eve Gartner. We met in Grand Rapids. And how long have you been practicing medicine, Dr. Cook?

A. Well, I graduated from medical school in 1989, and got an institutional license for practicing medicine at that time. I had my first state medical license in Michigan in 1990.

Q. So would you say about 14 or 15 years?

A. I would say more than 10 years, because you are in a training program during some of that time.

Q. So in that 10-plus-year period, you've personally performed between three and five D&E's; is that correct?

A. That I myself have performed, that would be correct.

Q. And none of them involved—that you've performed, none of them involved an extraction of a fetus that was living at the time the procedure was done; is that correct?

A. Right. Most of them involved babies that had been living within 24 hours, but not, that I am aware of, ones who were actually living at the time the procedure was performed.

Q. And you've never performed a D&E at 20 weeks or greater; is that right?

A. Not that I recall, no.

[1365]

Q. And in terms of the D&E's that you've supervised, those have been—there have been less than 20 of those, total; is that correct?

A. That is correct. And my role in some of those was not necessarily supervision. Sometimes it's providing ultrasound guidance and assisting a team of people working on the case.

Q. Okay. And of those 20 or so D&E's in which you either supervised or assisted in some way, fewer than 10 of those involved a fetus that was living at the time of the procedure; is that fair?

A. That would be correct.

Q. And as far as you know, you've never been present for a D&E that took place at 20 weeks or greater?

A. Not that I recall, no.

Q. And you don't consider yourself an expert in D&E techniques between 20 and 24 weeks gestation?

A. No, I consider myself aware and experienced with the various techniques that are involved. I just haven't personally performed them at that gestational age.

Q. Right. So you are not an expert in them, because you have never done them?

A. I am not an expert in performing D&E at 20 to 24 weeks.

Q. You don't even know any physicians that do D&E between 22 and 24 weeks; is that right?

A. I am not sure that is correct, no.

[1366]

Q. You testified earlier about induction abortions that you've done in your practice. Is it fair to say that in terms of inductions where the fetus is living at the beginning of the procedure and the induction is done prior to viability, that comes up in your practice once every few months?

A. No. I think I testified it comes up more than two times a month.

Q. I think that is what you said today, and I wasn't sure if I understood you, because I think in your de-

position you said "once every few months"; do you recall that?

A. I don't recall. I know it is not as frequent as the postviable ones, but I can recall two that I have done in the last couple of weeks.

Q. Okay.

A. So typically it is more like one to two a month.

Q. Okay. Can I just show you your deposition and see if we can clarify what I was misunderstanding?

A. Sure.

MS. GARTNER: Your Honor, do you have a copy of this?

THE COURT: No.

MS. GARTNER: There you go.

BY MS. GARTNER:

Q. Why don't you look at page 258?

MS. CLARK: Which page?

[1367]

MS. GARTNER: 258.

BY MS. GARTNER:

Q. If you want to start looking at page 258, at line 21 through 259, line 3.

A. I am sorry. What line numbers?

Q. I am sorry. 258, line 21 through 259, line 3.

A. Yes. I am sorry. Did you want me to read that?

Q. Just to yourself.

A. Okay.

Q. Just to refresh your recollection.

A. Yes, I did read it.

Q. Did you testify in your deposition that the circumstance of an induction abortion where the fetus is alive at the beginning probably couples up once every few months?

A. Well, the question was:

"Do you do this three or fewer times per year?"

And my response was:

"It's not that small, but it is not a large number."

And then, I mentioned I had done one, as I had, just the weekend prior to the deposition. And I said:

"But it probably comes up once every few months."

Q. Is that your testimony?

A. Well, the number is not continuous in that there may be [1368] some months we do several. There may be months we don't do any. But I think the average would be somewhere between 10 and 20 a year, which would be one to two times a month. It varies from year to year.

It is just not as frequent as the postviable ones.

Q. Okay.

A. And also has become less frequent, I think as I testified, just because the gestational ages are so much earlier. When I started into practice even in Grand Rapids we didn't generally have any babies that survived less than 24 weeks. And even then it was a few number. So oftentimes any induction less than 25 weeks was oftentimes considered a previable induction.

In the last several years we now have obtained a survival rate of 30 to 40 percent at 23 weeks. So sort of by definition we are doing it less frequently than we had in years past.

Q. Okay. And I think you testified that you will only perform an abortion in the case of either fetal demise or where the woman's life is at risk; is that correct?

A. When we think that the mom's at risk for significant medical concerns—it doesn't necessarily have to be immediately life-threatening—then we would end her pregnancy even if it was previable for the baby.

Q. Okay. Now, you have not written any articles about the relative safety of different abortion procedures; is that [1369] correct?

A. No, that's not been my primary research focus.

Q. Okay. And you have not written any articles about abortion other than on the topic of so-called "partial-birth abortion"; is that correct?

A. Again, it is a very broad area of obstetrics and gynecology, and my research focus has been in other areas.

Q. And as far as you know neither of your two or—am I correct you have had three publications in the area of so-called "partial-birth abortion," two or three?

A. Yes, it is just a small number. It's an issue that I was not even asked about until the last few years.

Q. Sure.

A. So my research history predated my even being aware of partial-birth abortion.

Q. Sure. And none of your publications in the area of so-called partial-birth abortion have been in the peer-reviewed literature; is that correct?

A. Well, the two that I am aware of off the top of my head are both in peer-reviewed publications.

Q. And you are referring to the letter to the New England Journal of Medicine?

A. Well, the one journal Issues of Law and Medicine is a peer-reviewed and abstracted and available on Medline. And the New England Journal is also a peer-reviewed journal.

[1370]

Q. Obviously, the New England Journal is a peer-reviewed journal, but your publication, that was a letter to the editor; is that right?

A. Well, you cannot write a letter to the New England Journal and just have it appear like an email or a comment to Time Magazine. It has to be reviewed by the editor. It has to be accepted for its basis in reasonable fact.

It has to be submitted from somebody that has reasonable expertise for an opinion that they think would benefit the readership.

They have a very strict editorial practice in the New England Journal since it is a preeminent medical journal. So you just can't have anyone submit a letter and have it published in the New England Journal of Medicine.

Q. Sure. I understand that. But a letter to the editor is not peer-reviewed in the way that we usually think of a study or some other publication as being

peer-reviewed by a team of physicians who review it and give comments back; isn't that fair?

A. I think probably it's fair to say that it's, you know, reviewed by the editors, but I am not certain that it is sent out for any review other than the editors that are present and the staff at the New England Journal of Medicine.

Q. Okay. And the other publication that you are referring to was an article that appeared in something called the Issues in [1371] Law and Medicine; is that correct?

A. That is correct.

Q. And you are telling me that is a peer-reviewed journal?

A. My understanding is that all publications in that journal are reviewed by outside reviewers.

Q. And are those outside reviewers physicians?

A. I am not certain if they are attorneys and physicians. I don't know. I just know it is a peer-reviewed journal, and I wrote it, and they made suggestions, as all peer-reviewed journals do for editorial content.

And then, you resubmit it, and then they decide they are going to print it.

Q. That was a publication that was co-authored by somebody named James Bopp; is that correct?

A. That is correct.

Q. And Mr. Bopp is well-known as an attorney who litigates on behalf of antiabortion groups, such as the National Right to Life Committee; is that right?

A. Well, that wasn't known to me at the time. I was just asked to help provide medical background for an article, and I agreed to do that.

Q. And did you know that the publication Issues in Law and Medicine is co-sponsored by a group that's called the "National Legal Center for the Medically-Dependent and Disabled"?

A. I did not have a lot of familiarity with this journal, nor [1372] do I to this day, since it is not a journal I generally review on a regular basis. But I have written articles for other journals like Phytochemistry that I don't subscribe to, either.

Q. Sure. I guess I am just trying to understand whether or not it was peer-reviewed.

And did you know that the other co-sponsor of this publication is a foundation called "The Horatio Storer Foundation," which is an affiliate of the National Right to Life Committee?

A. I have to admit you have an advantage over me about the background of this journal. I just don't know the specifics.

Q. Okay. So you don't really know whether it is a peer-reviewed journal?

A. No, I know it peer-reviewed because I had it peer-reviewed.

Q. Okay.

A. I submitted it. It came back with editorial comments from the editors. They asked me to make more comments. I corrected it. I sent it back. It is the same process I have done for The American Journal of Obstetrics and Gynecology, any other journal that I

submitted to. Journal Maternal Fetal Medicine, I go through the exact same process. You are not allowed to know, from my experience with journals, who your outside reviewers are.

They purposely send you back a form of your article without anybody's identification on it. And the reviewers are [1373] not supposed to know who is submitting it to eliminate other biases.

So the process for that journal is the same as the process for every other journal I have written an article for—

Q. Okay.

A. —from my experience.

Q. Now, Dr. Cook, you have not performed any clinical studies or research relating specifically to a method of abortion; is that right?

A. That's right. I think I stated that multiple times: it is not my primary research focus.

Q. I understand that, and I just need to go through these questions to make the record clear.

And you have served generally as a peer-reviewer for medical publications, correct?

A. I have in the past.

Q. Okay. But you have never peer-reviewed an article regarding a method of abortion; is that right?

A. That is correct. Generally, editors will send you articles related to areas that you have previously published in, so most of the articles that I get sent have to do with issues where I have published or done research that is known to the editors, which generally is in different areas.

Q. Sure. And do you plan to offer testimony today about the [1374] safety of a method of abortion that is sometimes called "intact D&X" or "intact D&E"?

A. I do.

Q. Okay. And at your deposition I think you stated that the sources for your understanding of how a so-called partial-birth abortion or intact D&E is performed is limited to Dr. Haskell's paper, Dr. McMahon's paper —I'm sorry. I'm losing my voice—Dr. McMahon's paper and to the ACOG statement of policy on intact D&X; is that correct?

A. Well, my direct experience with this procedure started with reviewing the submitted testimony of two high-profile practitioners of the procedure.

Q. That is Dr. Haskell and Dr. McMahon?

A. That is correct.

Q. Okay.

A. Although, I have subsequently had other experiences where I have been asked to review other people's cases, or in the case of Dr. Haskell, I was asked to review a videotape of him performing the procedure.

So I have had other experiences in that regard. And the elements of the procedure, as defined by the American College, are elements that I do perform in my own practice.

Q. Right. But my question is your understanding of the procedure is based on Dr. Haskell's and Dr. McMahon's descriptions, the ACOG definition, for lack of a better word, [1375] and the videotape you reviewed; is that fair to say?

A. That, and additionally my experience with elements of the procedure.

Q. Okay.

A. My personal experience with elements of the procedure.

Q. Let's talk about those. In terms of your experience with elements of the procedure, I think you testified earlier that you have done internal podalic version techniques. Or I am not sure if that the right word, but—

A. It's is a fair term.

Q. Okay. Is that right?

A. That is correct.

Q. But have you ever done that in the context of an abortion?

A. I have not in the context of an abortion.

Q. Okay. Now, let's talk about the video that you reviewed.

Am I correct that you reviewed that a few years ago in the context of when you were serving as an expert witness in litigation in the State of Missouri?

A. That is correct.

Q. And that video—I am really sorry about my voice—did not include the part of the procedure where the laminaria was either inserted or removed; is that correct?

A. That is correct.

Q. It was just the evacuation part of the procedure?

A. Well, and you could see the manipulation done to bring the [1376] baby down through the cervix. And then, you could see the portion that included the puncturing of the skull and evacuation—

Q. So the evacuation part; is that fair?

A. Well, the evacuation part is the end part.

Q. Oh, okay.

A. There's still the internal podalic version, bring the baby down through the cervix. The only part, as I recall—and it has been a number of years, as you stated—that was not included was the cervical preparation phase.

Q. Okay. And the visualization on that tape was not optimal; is that right?

A. Well, it wasn't as optimal as standing next to the practitioner, but you could see what was going on.

Q. Well, for example, at your deposition when we talked about this, you could not tell me what portion of the fetal head or neck was punctured with an instrument; isn't that right?

A. Well, the nature of the way that the procedure is performed, is the practitioner is placing their hand between the woman's cervix and the baby's head, and so the instrument is passing generally underneath their hand in the base of the baby's skull.

So I could see that it was generally in the area of the base of the baby's skull. You just couldn't see the exact puncture site—

[1377]

Q. Okay.

A. —from the vantage point I had of the video.

Q. Well, when I asked you if it appeared—when I asked you at your deposition if it appeared that it was being inserted in the back of the head or the back of the neck, you told me that you didn't think you could say from memory of visualizing the videotape; and that you had a limited visualization; and it was a number of years ago; and that you would have to see the videotape again, and in some time frame that is closer than several years ago.

Is that—are those correct statements?

A. Well, as I recall the question—and I can review the specific question in the deposition—it was could I see if it was in the neck or the base of the skull.

Well, that is a very narrow anatomic range. That I could see it was generally in that area, but I couldn't tell you if it was closer to the base of the skull or closer to the base of the neck. You could tell it was in this general anatomic area from mid-head to above the shoulders.

Q. Okay. But is it correct, Dr. Cook, that you did have a limited visualization of this videotape?

A. Well, I did not, again, have the visualization you would have if you were standing next to the individual, but you could certainly see what was going on, particularly if you delivered thousands of babies, as I have. It is easy to recognize and [1378] put into context what is going on.

Q. Why don't we go ahead and just look at your deposition on page 235?

Why don't you look at the entirety of your testimony on 235 and top of 236. Just through line 1 on page 236.

A. I think I read what you wanted at this point.

Q. Okay. And when I asked you:

"What portion of the fetal head or neck was punctured with an instrument" at page 235, line 1, did you say:

"Well, the visualization of the tape, as I recall, was not optimal. It was not—it wasn't like there was a zoomed in on just the baby and the perineum, so it's not an optimal situation to make an assessment."

Was that your testimony?

A. Well, the completion of the statement, that is true. But the completion of my answer to that very question was that:

"It appeared to be somewhere in the back of the baby's head."

Q. Okay. And then, did I ask you:

"Did it appear to be in the back of the head or back of the neck?"

A. And, again, the response just prior to that was:

"The baby's spine is up. It is underneath the [1379] operator's hand. I can't narrow the focus more than base of skull, back of neck."

Q. Okay.

A. We are talking now a matter of sonometers separation here.

Q. Sure.

A. So I guess I don't have that amount of precision from my visualization, but it certainly was a baby who was spine up. It certainly was a baby delivered to the level of the after-coming head. And it certainly was a puncture intentionally and volitionally done by the practitioner generally in the area of the back of the baby's neck.

Q. But my questions really, Dr. Cook, are not what happened, but just how—how easy it was for you to actually see what happened given that the videotape, according to your testimony, was not optimal and that it was several years ago.

So let me just ask you: when I asked you in your deposition if it appeared to be in the back of the head or the back of the neck, did you answer on line 12:

> "I don't think I could say that from my memory of visualizing the videotape. I would have to see the videotape again and in some time frame that is a little closer than several years ago."

Was that your testimony?

A. Yes. I just asked—

Q. Okay.

[1380]

A. —that my memory be refreshed by reviewing it again.

But, again, it was quite clear what was going on.

Q. No, my—I am asking you, Dr. Cook, was that your testimony at lines 12 to 15 in your deposition?

A. Yes. I stand by my testimony.

Q. Okay. Thank you.

Now, Dr. Cook, you have not been taught how to perform an intact D&E, have you?

A. I have not been instructed in that procedure.

Q. And you have never taught any of your medical students or residents how to perform an intact D&E, have you?

A. I hardly think it is something I would ever want to teach someone.

Q. Okay. And so the answer is: you have not done so?

A. That is correct. I have not done so.

Q. And you have never supervised someone else performing an intact D&E; is that correct?

A. That is correct.

Q. And you have never personally treated a woman that you were aware had had an intact D&E procedure; is that right?

A. I have been contacted by a person who had the procedure done and had a complication result from that—

Q. But you never reviewed her medical record, did you?

A. She was intending on sending me her medical records and then opted not to pursue litigation, so she did not send me the [1381] medical records, so I did not review her records. I just reviewed her oral relaying of

her medical history to me on a phone—on a phone conversation.

Q. Okay. And you have never personally treated as a physician a woman that you were aware had had an intact D&E?

A. Not that I am personally aware of as being confirmed as an intact D&E procedure.

Q. Right. And, in general, you've never reviewed any medical records relating to an intact D&E procedure; is that right?

A. No, I would not say that is correct.

Q. You have reviewed medical records of people who had undergone an intact D&E procedure?

A. As I was testifying in front of Congress, on other occasions part of the request from the committees that I was to appear before was to review and specifically comment on the medical necessity of this procedure in certain unique—I believe at that time—both fetal and maternal conditions.

And so this included the submitted medical testimony—the submitted testimony of the women's medical history that they relayed in their procedures as a justification for the procedure. I was then asked to review those specific cases and then comment on the necessity of the procedure in those specific cases.

Q. So you commented on women's statements to Congress about why they had particular abortion procedures; is that right?

[1382]

A. Yes. They were quite detailed descriptions of their own medical history.

Q. Those were the women's own accounts. You have not reviewed medical charts of those procedures; is that fair?

A. No, I volunteered to review medical charts if they felt that was necessary. And it was felt not to be necessary at the time.

Q. So just to be clear, you have not reviewed medical charts of women who have had an intact D&E procedure; is that right?

A. Correct. Just personally medical history, not medical charts.

Q. Okay. Thank you.

MS. GARTNER: Your Honor, we don't object to Dr. Cook being qualified as an expert in OB/GYN or MFM, maternal fetal medicine, generally. However, as with Dr. Sprang and Dr. Shadigian, we don't believe that Dr. Cook has the specialized expertise in intact D&E to describe how such a procedure is actually performed.

He hasn't taught the procedure. He hasn't supervised or been taught the procedure. To the exent he has viewed this videotape, we don't believe that his visualization at the time was good enough to really comment on how the procedure was done. Plus, he has testified it was several years ago. And he repeatedly said in response to my questions about it at his deposition that he really didn't recall and [1383] would need to see it again to provide an accurate response.

As the court has permitted with Drs. Sprang and Shadigian, we don't object to his providing his opinion about the safety of this procedure, based on his general expertise in OB/GYN and maternal fetal medicine, but

we would object to his setting forth any detailed descriptions of the procedure other than as necessary for him to provide his views on the safety.

And, of course, that wouldn't come in for the truth.

THE COURT: So I want to make sure I understand. He was offered as an expert in OB/GYN and maternal fetal medicine, as well as pregnancy termination. Your objection only goes to the pregnancy termination aspect, and then only to the extent of his qualifications on the technique of intact—

MS. GARTNER: Of intact D&E. And, actually, Your Honor, as well, we would object to his testifying about the technique of D&E in the 20 week post-time frame since he testified he has never done an abortion using the D&E technique after 19 weeks. And he himself considers himself not to be an expert in D&E from the 20 to 24 week time period.

THE COURT: All right. I understand.

Response?

MS. CLARK: Consistent with Dr. Sprang and Dr. Shadigian, we would go along with him not being qualified as an expert with respect to the specific techniques, but to the extent some of the techniques are consistent with other [1384] practices that he does in his own practice, such as internal podalic version, inserting laminaria, and those techniques, the separate parts, we believe he can testify to those separate parts.

And with respect to the D&E—

THE COURT: I don't know what parts you are talking about other than the podalic version. He didn't testify as to any other aspect.

MS. CLARK: Well, with the internal podalic version and the inserting laminaria, I believe that was his testimony earlier. And that he has performed breech presentation extraction, and the case of when there are twins and other things of that nature.

THE COURT: Well, obviously, as an obstetrician he is going to have to testify on various different aspects of delivery and pregnancy termination within his limited expertise.

But I think his testimony is very clear. He has testified himself that he is not an expert on D&E in the later weeks, that is 20 to 24 weeks, is the question he was specifically asked about. So he will not be qualified as an expert in the question of D&E for 20 weeks plus.

In addition, he will not be qualified as an expert in the technique of intact D&E. And he may testify, however, on either of those procedures to the extent that he has [1385] reviewed other people's descriptions or reviewed the videotape, to the extent he has any recollection of that, in order to opine on the question of the safety of either of those procedures.

Okay. That is it. Please resume your direct.

[CURTIS COOK, M.D.—DIRECT EXAMINATION—CONTINUED]

BY MS. CLARK:

Q. Briefly, Doctor, when did you first hear about the partial-birth abortion procedure? You alluded to this in your voir dire, but if you would go over it with the court.

A. Well, as I can best recollect, the first time it came to my attention was when a physician who at that time was heading up the society of obstetrical anesthe-

sia was called upon to testify specifically about the issue of anesthesia potentially causing the death of the fetus in these procedures.

He was then asked as part of his line of questioning on this area about other specifics related to the procedure that he was not comfortable addressing. And so he mentioned my name as a person who might be able to provide accurate medical background in some of these other areas.

And somehow—I don't remember the details—this led to me helping various different states and various different levels of federal government, as well, in trying to clarify the specific medical information that then led to the development PHACT organization for which I was asked to help [1386] formulate and have sort of a thoughtful, accurate and respected sort of position in order to kind of clarify, again, these medical issues.

So it is hard for me to remember sometimes what happened when. I just somehow found myself where I find myself today.

Q. Briefly, what do you understand the partial-birth abortion procedure to refer to?

A. I understand it to refer to a procedure that was described by Dr. Haskell at a National Abortion Federation seminar, which was essentially identical to the procedure being performed by Dr. McMahon and subsequently acknowledged to be performed by other physicians multiple thousands of times a year in this country, with several similar elements.

Most of those elements include first delivering —or first, I am sorry—dilating a cervix more so than you would with any other abortion procedure, using up

to 25 or maybe even 30 dilators at a time over an one-to-two day cervical preparation period. Then, bringing the woman in, generally on the third day, and converting the baby to a breech position, if the baby is not already presenting in a breech position. Delivering the baby up to the level of the after-coming-coming head.

Then, once the after-coming head is drawn down to the cervix, the base of the skull is then punctured with a [1387] sharp instrument, generally a scissor, and then a suction curette is introduced into the created defect in the base of the baby's skull, and intracranial contents, the brain contents are then suctioned out or evacuated to then cause collapsing of the skull bones to reduce the diameter of the baby's head size to be able to complete the remainder of the delivery.

* * * * *

[1390] with your congressional testimony?

A. They are.

Q. Doctor, what is your opinion as to whether the partial-birth abortion procedure is ever medically necessary to protect the health interest of women facing high-risk pregnancies?

A. I don't believe that it is ever medically necessary. It has even been stated by the College: there is no situation—the American College of OB/GYN—there is no situation where they can think of that this is the only option available.

This is the prevailing thought, that there are other methods that are available, safer, well-established methods. So I don't believe it has anything to offer us in the area of treatment of complicated pregnancies.

Q. Dr. Cook, what is your opinion as to whether the partial-birth abortion procedure presents risks to women undergoing that procedure as compared to other methods of pregnancy terminations?

A. Well, I have grave concerns that elements of the procedure have risks for both immediate complications and long-term complications that I don't feel justify utilizing the procedure when you have other safe procedures available.

Q. Doctor, you testified that you performed quite a few less D&E's in your career than induction; is that correct?

A. That is correct.

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[1407]

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Q. In comparing the D&E procedure to the partial-birth abortion procedure, in what ways do you understand those two procedures to be distinct procedures?

A. I think the greatest distinction is the amount of cervical dilation that they attempt to achieve with the D&X procedure, being a much greater amount of cervical dilation. Again, using up to 25 dilators over a two-day preparatory period.

The D&E procedures I am familiar with and that I have seen described and that I have performed or observed generally use a lesser number of dilators, usually six or less, and usually for a single preparatory day prior to doing the procedure.

* * * * *

[1412] pregnancies?

A. Well, it is my opinion based upon a number of materials I have reviewed over the years, and my experience in dealing with complicated pregnancies on a daily basis, that there are other safer and readily available alternatives to emptying a uterus in the late second-trimester or even early third-trimester that allow us the optimal ability to care not only for the mother and any complications she may have, but also the optimal ability to get helpful information from the fetus.

In addition, do I not only feel this procedure doesn't offer anything new to what we have available, there are elements of the procedure that concern me for both short-term and long-term potential for complications.

Q. And what are some of those elements of the procedure that concern you in terms of the short-term and long-term risks?

A. Well, in the short-term, whenever you are doing an excessive amount of cervical manipulation or dilation, it does increase your risk for bleeding, laceration and infection.

Whenever you are doing intrauterine manipulation of the fetus to the extent that you are doing an internal podalic version, you increase the risk for complications, such as trauma to the uterus or bleeding or infection. And whenever you are potentially exposing a very vascularized cervix to a collapsing skull, boney skull; there is the potential for increasing risk for bleeding and lacerations as part of some of [1413] the short-term concerns.

Q. And with respect to the long-term concerns that you testified about?

A. In regards to the long-term concerns, they are predominantly focused on the area of this overdilation, massive overdilation of the cervix that concerns me for the ability to maintain the integrity of the cervix for subsequent pregnancies.

Q. And why does the overdilation concern you about future pregnancies —

MS. GARTNER: Objection, Your Honor. We object to the use of the term "overdilation." I don't think there is any foundation for the term "overdilation" in this context.

THE COURT: Sustained.

BY MS. CLARK:

Q. Doctor, when you use the term "overdilation," what did you mean by that?

A. I guess what I mean is manyfold greater than the amount of dilation used for any other abortion technique.

Q. And based on your understanding—

MS. GARTNER: I am sorry, Your Honor. Again, I think there is lack of foundation that there is more dilation in an intact D&E than there is with an induction.

THE COURT: I am going to allow him to testify given his—I certainly heard from other doctors to the contrary [1414] over the last three weeks. I will give the testimony on this issue the weight I believe it is entitled to.

MS. GARTNER: Okay. Thank you.

BY MS. CLARK:

Q. Doctor, when you say "overdilation," what is your basis for believing there is a certain amount—there is overdilation in the D&X procedure compared to other abortion procedures?

A. Well, as I understand the D&E procedure to be described and as I have seen it performed and as I have performed it, we generally would place maybe up to six dilators at a time, or six laminaria.

And by the description of the practitioners who do the D&X procedure they are placing up to 25 dilators at a time. So, to me, that is manyfold more than we would use for any other abortion technique. In the first-trimester we don't use laminaria, generally. We use smaller mechanical dilators where we are dilating generally to somewhere, eight, nine, ten millimeters.

Q. And how does the amount of dilation relate to the long-term complications you were touching on a few moments ago?

A. Well, there's an increasing body of evidence that people who even have first-trimester abortions done suffer an increased risk of premature deliveries, mostly secondary to cervical-incompetence-related issues with subsequent pregnancies.

[1415]

And if they experience that with the relatively smaller amount of cervical dilation required for a first-trimester procedure, then I am necessarily concerned about what experiences they might have when you are dilating at manyfold greater than that.

Q. Doctor, in your opinion and based on your understanding of the D&X procedure, are there any maternal health risks that are unique to the D&X procedure itself that causes you concern with the D&X procedure?

A. Well, the elements are unique in their combination, although different elements are performed in other situations. But the combination of the overdilation or the manyfold more dilation of the cervix, together with the intentional internal turning of a singleton pregnancy in a limited uterine environment, and the potential risk for the collapsing skull, all pose concerns that I think go over and beyond other abortion techniques.

Q. Doctor, how long have you been providing care to women with complicated pregnancies?

A. Well, we started caring for complicated pregnancies at the very beginning of my residency training in 1989, but I am more exclusively cared for only complicated pregnancies from 1993 forward.

Q. Have you ever experienced a clinical situation in which the partial-birth abortion procedure has ever been required or * * *.

* * * * *

[1465]

* * * * *

[CROSS EXAMINATION BY MS. GARTNER]

Q. Okay.

Okay. Let me ask you this. I think I understand where you are going with what you just said, but in the context of these conditions preeclampsia, HELLP syndrome, serious renal conditions where you are

trying to minimize the risk of blood loss for the reasons that you've explained, one of the reasons that you prefer induction in those situations is that you're not putting instruments in the uterus and you are not putting [1466] the woman at risk of uterine perforation which would cause blood loss; is that a fair statement?

A. I believe it is a fair statement, although it is a complex statement, but I think I agree with all of it.

Q. Did you want me to restate it? Did you follow it?

A. It would be more helpful, maybe, if you say it one more time.

Q. Okay. For those women: preeclampsia, HELLP syndrome, renal conditions where you are trying to minimize the risk of blood loss, one of the reasons you prefer induction for those women if they are terminating is because in the induction method you are not putting instruments in the woman's uterus, so you are not putting her at risk of perforation from those instruments; is that a fair statement?

A. That is a fair statement.

Q. Okay. So if you had a patient with one of those conditions, and you were just focusing on the potential risk from blood loss and no other complication, and if the woman absolutely refused to have an induction abortion, wouldn't you agree that intact D&E would be safer for her than a D&E, specifically in terms of reducing the instrumentation in the uterus?

A. Yes, I assume we are talking about—

Q. At comparable gestational ages?

A. Yes, at comparable gestational ages, then intuitively it [1467] would make sense that anything

that involves less instrumentation would reduce the risk of laceration or perforation.

* * * * *

[1472]

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Q. Just to summarize this, you would agree that for some women with cardiovascular conditions under some circumstances D&E may be a superior technique to induction?

A. It may be a superior technique to induction—

Q. Okay.

* * * * *

[1473]

A. —in some special circumstances.

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[1486]

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Q. We are going to get to that. I need to—for my questions I need to break it into pieces.

So just it terms of just the instrumentation part, you would agree that with respect to the instrumentation, comparing D&E with intact D&E at the same gestational age, there may appear to be some benefits to intact D&E; is that a [1487] fair statement?

A. As related to instrument passing?

Q. As related only to instrument—the instrumentation in the uterus.

A. Yes, that is true.

Q. And I think you've actually—I think you actually testified in Nebraska that you think that that aspect of the procedure, just the instrumentation in the uterus, would be safer in an intact D&E than a disarticulation D&E; is that correct, at the same gestational age?

A. Intuitively, that would make sense. I don't know of data one way or another on that specific issue.

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[1500]

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[Q.] Am I correct that a low transverse cesarean section is the most common type of prior uterine scar?

A. That is correct.

Q. And for a woman with that type of scar, the risk of uterine rupture during an induction abortion is approximately 1 in 200; is that correct?

A. Not necessarily. That is the risk of rupture at term for a normal labor process.

Q. Okay. And do you have a sense of what the risk would be at a 20 to 24 week induction abortion?

A. I would suspect it would be less.

Q. I think you also—you consider those to be acceptable risks; is that correct?

A. I do in the situation where you can address the [1501] complication, meaning that OB anesthesia or capability, trained personnel to deal with it.

For instance, a lot of smaller hospitals in the United States are no longer doing VBAC's because they don't have the ability to address even a rare complications very rapidly.

Q. For the record why don't you explain what a VBAC is?

A. I am sorry, a vaginal birth after cesarean delivery.

Q. And it is an acronym, VBAC?

A. It is, yes.

Q. So you are saying that that is a—the risk of uterine rupture is acceptable if you have the capacity to treat the woman after the rupture; is that correct?

A. Correct.

Q. And would that tend to result in the need for a hysterectomy?

A. Not necessarily. Most times we do not have to do hysterectomies for uterine ruptures.

Q. Okay. But obviously it results in some significant blood loss and other complications?

A. It does require additional surgery most times.

* * * * *

[1508]

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Q. Okay. And I think what we talked about in your deposition was there would be situations where that occurs where the fetus is delivered to the point of the after-coming head and, if the patient started developing some sort of unstable situation, such as bleeding or infection, then you would recommend progressing to definitive completion of the delivery rather than waiting for her to deliver on her own; is that correct?

A. That is correct.

Q. And you would have several options for how to effectuate that; is that correct?

A. That is correct.

[1509]

Q. And one of those options would be manually delivering the head with forceps; is that—I am sorry—manually. One option would be manually delivering the fetus; is that correct?

A. "Manually" meaning forceps?

Q. Using manipulations with your hands to deliver the head?

A. Yes, that is one option.

Q. Okay. And another option would be using forceps to effect the delivery?

A. That would be another option.

Q. Okay. Now, if you attempted—and then another option would be to make incisions on the woman's cervix; is that correct?

A. An incision. But, generally, those would be after I have tried medical options, first.

Q. Sure. Okay. But in that case where the woman was bleeding or infected and her situation was unstable, if you gave her nitroglycerin and it didn't work fairly rapidly, then you would have to move to another step; is that correct?

A. That is correct.

Q. And in that context, if you couldn't deliver the head with your hands, you would then have to consider either the use of forceps or the use of Duhrssen's incisions; is that correct?

A. That is correct.

Q. Okay. And in your practice when you had the choice between forceps and Duhrssen's incisions, you would probably [1510] choose Duhrssen's incisions; is that correct?

A. It would depend on the clinical situation. If it is a viable baby, I generally would do forceps.

Q. Okay.

A. If it is previable baby, then I might more frequently go to an incision, if all the other elements have failed prior to that.

Q. Okay. And am I correct that when you make the —when you do the Duhrssen's incision procedure, you make anywhere from one to three incisions on the woman's cervix?

A. That is correct.

Q. Okay. And the largest incision you might have to make is maybe 2 centimeters in length?

A. One to 2 centimeters, yes.

Q. And it is the full depth of the cervix?

A. No.

Q. It is not the full depth of the cervix?

A. It is the full depth of the completely effaced cervix. But once the cervix retains its normal length, again, then it makes up a very small portion just the end of the cervix. The normal cervical length in pregnancy is 3 to 4 centimeters.

Q. Okay.

A. Sometimes more.

Q. Okay. Do you want to just take a look at your deposition at page 195? Do you want to look at lines one through six? I [1511] asked you:

"What is the largest incision you have to make?"

And you said:

"Maybe two centimeters in length."

And I asked you:

"How about in depth?"

And you answered:

"It is a full depth, and it is all the way through the cervix, so probably the length is the best way to evaluate how much is there."

Was that your testimony?

A. That was my understanding of dealing with the effaced cervix, what I understood you asked me right now is: what does that represent as a portion of the total cervical length?

Q. Okay. And am I right that you would make that kind of incision with scissors?

A. Usually, yes.

Q. And you've performed this type of procedure, right?

A. I have.

Q. And you believe that a Duhrssen's incision is more gentle than dilation using osmotic dilators?

A. I don't agree with that. Those are not—that is not an option in that situation to use osmotic dilators.

Q. Okay. But in general, in terms of looking at the impact [1512] on the cervix, you believe that a

Duhrssen's incision is more gentle than osmotic dilation; is that correct?

A. In relation to long-term potential complications with the cervix, yes.

Q. Okay. And you believe that a Duhrssen's incision is part of the natural physiologic process; is that correct?

A. Not exactly. What I said was that cervical lacerations occur frequently as a result of a normal labor process, and the amount of cervical laceration that we see is very similar to the controlled surgical incision we make on the cervix.

Q. Did you testify in Nebraska last week that Duhrssen's—you were asked:

"Doctor, is it part of the natural"—

MS. CLARK: Can I get a page number?

MS. GARTNER: Sure. Let me hand this—

THE WITNESS: I think I can answer your question, though. I believe I was asked, you know, "is it more traumatic," and things of that nature.

And I said:

"It is a variation on a normal process," meaning that we actually help the cervix do what it would sometimes do on its own when it causes laceration to facilitate delivery.

BY MS. GARTNER:

Q. Okay. Yes. I think that is what you testified to in [1513] Nebraska.

A. Okay. I am trying to save time.

Q. Okay. So, just to be clear about that, you would agree or you would—you would—it is your opinion that incisions in the cervix that could be up to 2 centimeters long, and there could be anywhere from one to three of them, that doing that type of incision would be more physiologic than osmotic dilation with laminaria?

A. That is correct.

Q. And it is your belief that that type of incision has no implication for the woman's future child bearing?

A. That is correct.

* * * * *

[1517]

* * * * *

Q. But I understand that you would choose induction of labor. But in a situation where, for whatever reason, either patient reference or some overriding medical concern induction was not an option, between 22 and 24 weeks, you do believe hysterotomy is safer than D&E; is that correct?

A. In the clinical scenario you are asking me, yes.

Q. And, again, the hysterotomy would have implications for the woman's ability to have vaginal deliveries in the future; is that correct?

A. Yes.

* * * * *

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C 03-4872 PJH

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. AND PLANNED PARENTHOOD GOLDEN GATE, PLAINTIFFS

v.

JOHN ASHCROFT, ATTORNEY GENERAL OF THE UNITED STATES, IN HIS OFFICIAL CAPACITY, DEFENDANT

TRANSCRIPT OF PROCEEDINGS
Thursday, Apr. 15, 2004
Volume 10

BEFORE THE HONORABLE
PHYLLIS J. HAMILTON, JUDGE

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* * * * *

[KANWALJEET S. ANAND, M.D.—DIRECT TESTIMONY]

[1540]

THE WITNESS: Thank you.

BY MS. NORONHA:

Q. Good morning, Dr. Anand.

A. Good morning.

Q. Dr. Anand, what is your occupation?

A. I'm a pediatric specialist specialized as a pediatrician taking care of critically ill infants and children.

Q. Doctor, why are you testifying here today?

A. I was requested to do so by the U.S. Department of Justice based on my background and research.

Q. Is there a research in any particular area?

A. Research in the area of development of the pain system and stress responses during fetal and neonatal life.

Q. Dr. Anand, I have handed you what has been marked as Exhibit A-1. What is this document?

A. This is a printout of my curriculum vitae.

Q. Is this an current and updated copy of your C.V.?

A. Actually, this a copy that was printed out in January of this year. And there have been a couple of changes since then.

Q. What changes have occurred since January?

A. Some of the papers that were in press have been published, and also I have received an award from the Broad College of Pediatrics and Child Health in the UK.

MS. NORONHA: Your Honor, at this time I offer [1541] Exhibit A-1 into evidence.

THE COURT: Any objection?

MS. GARTNER: No, Your Honor.

THE COURT: It will be admitted.

THE CLERK: A-1 into evidence. (Defendant's Exhibit A-1 was received in evidence.)

BY MS. NORONHA:

Q. Doctor, where did you go to medical school?

A. I went to medical school in Mahatma Gandhi Memorial Medical in Indore, spelled as I-N-D-O-R-E.

Q. What degree did you receive from that college?

A. I received a degree shortened as MBBS, which stands for Bachelor of Medicine, Bachelor of Surgery. And it's equivalent to the MD degree in the U.S.

Q. Did you do an internship after medical school?

A. Yes. I did a rotating internship at Yeshwantrao Hospital. I will spell that: Y-E-S-H-W-A-N-T-R-A-O Hospital, and at Hindu Rao Hospital. H-I-N-D-U. Next word: R-A-O, Hospital. And that is in Delhi.

Q. Did you also do a residency program in India?

A. Yes. Following this rotating internship through different departments, I came back to the University of Indore, and I was registered and working in a three-year residency program for postgraduate training in pediatrics.

[1542]

Q. Did you complete that program, Doctor?

A. No, I didn't. I completed one year of that three-year program. And then, during that year I had applied for the Rhodes Scholarship, and I received that, and went to Oxford, University of Oxford for a period of one year.

Q. How long were you at Oxford?

A. I was at University of Oxford from October 1982 to November of 1985, so about three years.

Q. What degree did you receive from Oxford?

A. I received what is called a "D.Phil.," or Doctor of Philosophy degree from the Faculty of Clinical Medicine.

Q. Doctor, did you perform any research as part of your studies at Oxford?

A. Yes, certainly. The D.Phil. degree at Oxford is primarily a research-based degree, and I performed research on the hormonal and metabolic responses of newborn infants undergoing surgery and anesthesia.

Q. What was the result of the research that you performed?

A. We had postulated that newborn babies may not be able to mount a significant response, hormonal stress response to a surgical operation. And our initial studies showed that it was the opposite, that babies had a massive hormonal stress response, three to five times that of adult patients undergoing similar types of surgery.

We then designed some studies to look at the effect [1543] of anesthesia on this hormonal stress response. The reason being at that time the standard practice was to perform operations on babies without giving them any pain relief or anesthesia.

And we felt part of the reason that they have a massive hormonal stress response is that they were essentially awake during operative procedures. And so when we did these randomized controlled trials looking at the effects of anesthesia in newborn infants, we found that their stress responses were markedly re-

duced and their complications after the surgery were also diminished.

Q. Doctor, did you do any additional training after you acquired your D.Phil. from the University of Oxford?

A. Yes. After that I moved to Harvard Medical School and Boston Children's Hospital where I did a postdoctoral fellowship in the Department of Anesthesia.

Q. What sort of work did you do in your postdoctoral fellowship?

A. I continued this line of investigation. I was very intrigued by the fact that giving potent anesthesia can reduce complications following surgery. So I wanted to study babies that are critically ill after an operative procedure. And Boston Children's was the one place in the world that had the largest number of babies undergoing open heart surgery.

So we designed some novel anesthetic techniques. [1544] And when we did a randomized controlled trial found that babies who had received the deep anesthetic during open heart surgery had not only significantly less complications, but their survival after the operation had improved.

Q. So were you a member of the Department of Anesthesia at Children's Hospital?

A. Yes, I was. I was at the rank of an instructor at the Anesthesia Department.

Q. Did you do any teaching while you there?

A. Part of my duties, in addition to the research, involved giving lectures or doing journal club or other

things for anesthesia residents and fellows who were in the Department of Anesthesia at that time.

I also did a Biostatistics course for helping develop their research skills in the anesthesia field.

Q. Doctor, where did you go after you completed your postdoctorate research fellowship at Children's Hospital?

A. I applied for residency programs to train in pediatrics, and I was matched at Boston Children's Hospital. So I did a three-year residency training in pediatrics after this fellowship.

Q. Were you also at Massachusetts General Hospital?

A. Yes. At the completion of my residency training in pediatrics I went to subspecialize in the area of Neonatal and Pediatric Intensive Care, and so I moved to Mass. General [1545] Hospital, still within the Harvard Medical School System, to do a clinical training fellowship in the pediatric and neonatal ICU's at Mass. General.

Q. What did you do after you completed your work at Massachusetts General Hospital?

A. I spent many years in postgraduate training. And it was time to find a job. I was appointed as Assistant Professor of Pediatrics Anesthesiology and Psychiatry at Emory University in Atlanta.

Q. Did you do any research while you were at Emory?

A. Yes, I did. I continued this line of research, because I had convinced myself, at least, that premature and full-term newborn infants are sensitive to pain.

I designed some analog models to look at the long-term effects of pain during early life, as well as design some novel ways of giving pain relief to premature and full-term infants.

Q. Did you also care for patients while you were at Emory?

A. Yes. While at Emory I was also a pediatric intensivist, which means I was taking care of critically ill children in the pediatric ICU at two different hospitals. One was Egleston Children's Hospital, which is E-G-L-E-S-T-O-N, and the other was Hughes Spaulding Children's Hospital, both in Atlanta.

Q. Doctor, when did you leave Emory?

A. I left Emory in September of 1997 and moved to University [1546] of Arkansas for Medical Sciences.

Q. Is that where you are presently?

A. That is where I am at present.

Q. What is your present position at the University of Arkansas?

A. I'm currently a Professor of Pediatrics, Anesthesiology, Pharmacology, and Neurobiology at University of Arkansas for Medical Sciences. I also work at Arkansas Children's Hospital as a pediatric intensivist, and on the sedation service at Children's Hospital.

Q. So what sort of work do you do as a practicing pediatric care intensivist at the Children's Hospital?

A. My clinical work includes taking care of infants and children who are severely ill from multiple different illnesses and are admitted to the pediatric ICU at Arkansas Children's Hospital.

I also work on a sedation service which provides deep sedation and light anesthesia to children all over the hospital whenever they are undergoing any kind of procedure.

Q. So do you administer anesthesia to your patients?

A. Yes. Part of my training as an intensivist includes the use of sedative anesthetic and analgesic drugs.

And on the sedation service, in particular, I act as an anesthesiologist doing a preanesthetic evaluation, providing the anesthesia, and then doing a postanesthetic evaluation the [1547] Children's Hospital.

A. Doctor, are you a board certified anesthesiologist?

A. No, I am not.

Q. Well, what is the difference between what a board certified anesthesiologist does and what you do?

A. There is some degree of overlap in the training of critical care specialists and anesthesiologists. The anesthesiologist provides anesthesia in the operating room, and uses a multitude of different techniques, some of which are applicable outside the operating room, as well.

The intensivist is primarily concerned with providing sedation and analgesia for invasive procedures, either in the ICU or as we do as part of the sedation service.

So there is a little bit of overlap between the two fields.

Q. You also mentioned that you have an adjunct appointment in the Department of Anesthesia at the University. What do you do in that capacity?

A. I help with the training of residents and fellows in the Department of Anesthesia. But this is, again, because this is within the same medical school, when I am teaching pediatric residents and fellows, there will be in the same lectures or journal clubs there will be the anesthesia residents and fellows included in that.

Many of the anesthesia fellows will rotate through [1548] the pediatric ICU. And in that capacity I help train them in the care of critically ill children.

Q. Doctor, what is the Pain Neurobiology Laboratory at Arkansas Children's Hospital?

A. This is a laboratory that I am the Director of the Pain Neurobiology Lab at the Research Institute. And the focus of this lab is performing research on the short-term and long-term effects of pain, particularly in animal models of fetal and neonatal pain.

Q. What sort of research are you presently conducting in those areas?

A. There are several clinical and experimental studies underway right now. Clinical studies include a multinational randomized clinical trial, for which I am the study chairman, where we are coordinating the efforts of 16 different centers and looking at the effects of morphine given as pain relief in premature infants who are ventilated.

There are a couple of other minor clinical studies, as well.

On the experimental side, we are performing research on the impact repetitive pain may have on the

development of the brain, looking at cell death within the brain and looking at some anesthetic and analgesic drugs that can eliminate some of the long-term detrimental effects of pain.

This is performed primarily in a rat model of [1549] neonatal pain.

Q. Doctor, are you presently conducting any clinical studies on pain in the human fetus?

A. No, I am not.

Q. Have you ever participated in such studies in the past?

A. While I was at Oxford I was involved somewhat peripherally in two studies that were ongoing at that time. I am a co-author on one of the publications that resulted from one of those two studies, but I did interact with those researchers, review the protocol and help in the interpretation of their results.

Since then, I have not had any—I have not performed my own research on fetal—in the fetal setting.

Q. Doctor, are you board certified in any medical specialty?

A. I am a Diplomate of the American Board of Pediatrics and the Subboard of Pediatric Critical Care Medicine.

Q. Where are you licensed to practice medicine?

A. In the State of Arkansas.

Q. Approximately how many articles have you published?

A. As listed in this C.V., there is about 200 articles that have been published.

Q. Have these articles addressed the topic of fetal pain?

A. To some extent they have. A few articles have focused on the early development of the pain system and have addressed the question of consciousness as it develops during fetal and [1550] neonatal life, and have included subsections on fetal pain and fetal consciousness.

Q. Doctor, do you perform any peer review of scientific papers?

A. Yes. Certainly I do. I am on the editorial board of a journal called Critical Care Medicine. And up until December of last year, I was also on the editorial board of a journal called Biology of the Neonate.

In addition to these editorial appointments, I perform peer review of papers submitted to multiple different journals: Anesthesiology, Analgesia, American Journal of Obstetrics and Gynecology, the neuroscience journals and a large number of pediatric journals, as well.

Q. Doctor, what is the Maternal Fetal Research Network of the NIH?

A. This is a research network that is funded through the National Institute for Mental Health and is a multidisciplinary group of researchers that are focused on studies of fetal physiology, neonatal physiology, and the impact of maternal stress or perinatal adverse experiences on long-term outcomes.

Q. And you are a member of this network?

A. Yes, I was invited to be a member of this network.

Q. Doctor, have you ever testified as an expert witness before?

A. During the course of my clinical work I have testified as a [1551] fact witness in a number of cases, but in the process of reviewing my credentials I was classified as an expert in the area of pediatrics and pediatric critical care in some of those.

There is one other case in the last four years where I was invited as an expert on the pharmacology of anesthesia and analgesic drugs.

Q. Have you ever testified in a case involving abortion procedures, aside from the three cases in which you have testified regarding the Partial-Birth Abortion Ban Act of 2003?

A. No, I have not.

MS. NORONHA: Your Honor, at this time we offer Dr. Anand as an expert in the areas of fetal biology—fetal neurobiology—excuse me—fetal pain and the pharmacology of anesthetic drugs.

MS. PARKER: Your Honor, if I might, I would like to do some voir dire.

THE COURT: All right.

[KANWALJEET S. ANAND, M.D.—VOIR DIRE EXAMINATION]

BY MS. PARKER:

Q. Good morning, Dr. Anand. Nice to see you again.

A. Good morning, Ms. Parker.

Q. As I understand it, you are a pediatric intensivist; is that right?

A. That is correct.

[1552]

Q. You are not an obstetrician?

A. No, I am not.

Q. And you are not a gynecologist?

A. No, I am not.

Q. In fact, other than as a medical student, you have no training in either obstetrics or gynecology?

A. That is correct. My training was during my medical school days, as well as during the rotating internship that I had completed in India.

Q. But since then you have no training in obstetrics or gynecology?

A. Absolutely right.

Q. And you have never performed an abortion procedure?

A. No, I have not.

Q. You have never written any articles about abortion procedures?

A. That is correct.

Q. And you've never conducted or participated in any studies on any method of abortion, have you?

A. That is correct.

I have not participated in those kinds of studies.

Q. And before you spoke with counsel for the government in this case, you thought the Partial-Birth Abortion Ban Act of 2003 covered the vast majority of procedures for abortions; isn't that right?

[1553]

A. Yes, that was my somewhat ignorant impression.

Q. But counsel for the government told you that the procedure that the Act banned was the dilation and extraction, or D&X procedure; is that right?

A. Yes, they did. And after that initial telephone contact, I received a copy of the Act, and I read through that, and then informed myself as to what it is all about.

Q. But before that conversation and receiving a copy of the Act, you didn't have much of an understanding of the intact D&E procedure; isn't that right?

A. That is right, if the intact D&E procedure is what you call the D&X procedure.

Q. In fact, I think you told me at your deposition you went on Google to look for information about it?

A. You're absolutely right.

Q. And your understanding even now is only rudimentary?

A. I agree with that.

Q. So you've never performed an intact D&E procedure?

A. No, I have not.

Q. Never observed one happening?

A. No, I have not.

Q. And you don't consider yourself an expert on that procedure?

A. You're absolutely right. I don't consider or claim to be an expert in that procedure.

[1554]

Q. I also think on direct you indicated that you're not an anesthesiologist?

A. I am not a board certified anesthesiologist.

Q. You have never had a board certification in that specialty area; is that right?

A. That is correct.

Q. You are not a member of any professional organization relating to anesthesiology?

A. No, I am not.

Q. You are not trained or certified to deliver anesthesia to patients?

A. I do deliver anesthesia to patients under my certification as a pediatric critical care specialist.

But those are overlaps between the functions of a pediatric intensivist and an anesthesiologist.

Q. But you don't do that in the context as an anesthesiologist?

A. I do that as a practicing clinician at Arkansas Children's Hospital.

MS. PARKER: Your Honor, may I approach the witness?

THE COURT: Yes.

BY MS. PARKER:

Q. Dr. Anand, if you could take a look at your deposition which occurred February 17th at page 214. And I would like to direct your attention to lines three through 10. And there you [1555] are asked in response to a question by your counsel that said:

"Dr. Anand, earlier Ms. Wigmore asked you whether you were an expert in anesthesiology, and you said that you were not an expert in anesthesiology. What did you mean by that?" And you responded:

"Simply means that my expertise is in the pharmacology of anesthesia and analgesic drugs, but I don't practice as anesthesiologist, and I'm not trained or certified to deliver anesthesia to any patients."

Do you see that?

A. Yes, I certainly—could I direct your attention to page 44 of the same deposition?

THE COURT: This is a bit unusual.

MS. PARKER: Yes. I think I am the one who gets to ask the questions, Dr. Anand.

THE WITNESS: Your Honor, the deposition occurred—

THE COURT: Well, first of all, this is a voir dire procedure. She is testing the extent and scope of your qualifications. Counsel for the government will have an opportunity to draw our attention to any other pages of the deposition that are pertinent.

THE WITNESS: Certainly, whatever you desire.

BY MS. PARKER:

[1556]

Q. So you currently don't act in the area of obstetric anesthetics; is that right?

A. That is correct.

Q. And you have not conducted any studies measuring the effects of anesthesia on fetuses; isn't that right?

A. That's right.

Q. You don't consider yourself to be an expert in anesthesiology; isn't that right?

A. That is right.

Q. You indicated that you spend some part of your time working with the Department of Anesthesiology at the University of Arkansas, I believe?

A. Yes, I have an adjunct appointment in the Department of Anesthesiology, but my primary appointment is in Department of Pediatrics.

Q. In fact, you spend 99 percent of your time in the Department of Pediatrics; isn't that right?

A. I think it is 99 percent of my effort, rather than my time. And that part of that effort also subserves the functions of the Department of Anesthesiology or Pharmacology or Neurobiology.

As an example, suppose I apply for an NIH grant and I receive an NIH grant, the grant total will be included in the research funding for Department of Anesthesiology, as well as my primary department, which is Department of Pediatrics.

[1557]

Q. But at your deposition you told us that you spend less than 1 percent of your time in the departments other than the Department of Pediatrics; isn't that right?

A. Less than 1 percent of my effort, not time.

Q. Okay.

A. And—

Q. And all of your salary comes entirely from the Department of Pediatrics; isn't that right?

A. Absolutely right.

Q. So, Dr. Anand, you also claim to be an expert in fetal pain; is that right?

A. Yes, I do.

Q. But you are not currently conducting any research on pain in the human fetus; isn't that true?

A. That is true. I am not currently conducting any research in the area of fetal pain, although during my entire research career I have closely followed the literature pertaining to fetal pain over the last 20 plus years.

And I have frequently served as a reviewer for studies that have looked at fetal responses to pain.

Q. But you yourself are not currently conducting any research on fetal pain?

A. You're right.

Q. And all the research you are currently conducting is on animal models or pre-term infants or neonates; is that right?

[1558]

A. That is right.

Q. And, in fact, all of the research you have conducted in the past has focused on newborn infants; isn't that right?

A. Except as noted above in relation to the studies I have participated in University of Oxford, all of my research has been in animal models of neonatal pain and pre-term infants.

Q. But there is a huge difference between pre-term infants and fetuses; isn't that right, in terms of their experiential contacts, the physiological differences and differences in terms of their environment?

A. You're absolutely right.

Q. And the doctoral thesis you just mentioned also involved premature infants; isn't that correct, not fetuses?

A. Yes, premature infants and full-term infants.

Q. It did not focus on fetal pain or fetal anesthesia?

A. It did not focus on fetal pain or fetal anesthesia.

Q. In fact, the only work on fetal pain that you have done is a study you participated in peripherally while you were at Oxford?

A. Yes. Like I mentioned before, there were two studies that I participated in.

Q. That was over 20 years ago; isn't that right?

A. Yes.

Q. And one of those studies was by a Joachim Partsch; is that right?

[1559]

A. That's right.

Q. Your role in that study was simply to review the study protocol at departmental meetings and helping interpreting the results; isn't that right?

A. That is correct.

Q. You weren't an author on that publication?

A. I was not a co-author on that publication.

Q. And the second study you participated in also occurred in the 1980's; isn't that right?

A. That's right.

Q. And that is the study you indicate you were a co-author on?

A. Yes, I was the second author on that publication.

Q. But that study did not conclude that a fetus feels pain, did it?

A. No, it wasn't designed to look at the question of fetal pain.

Q. So it wasn't even designed to investigate the question of fetal pain?

A. That's right. At that time fetal or neonatal pain had simply not been addressed in any medical research that I'm aware of.

Q. So the two studies you participated in in the 1980's didn't really look at the whole issue of fetal pain. And since the 1908's [*sic*], you have not participated in any studies on fetal pain; isn't that right?

[1560]

A. I have not performed any studies on fetal pain since the 1980's, you're right.

Q. Are you aware of any studies of fetal pain during the intact D&E procedure?

A. I am not aware of any such studies.

Q. Are you aware of any articles on fetal pain during the intact D&E procedure?

A. That topic to the best of my knowledge has not been researched or published as yet.

Q. So in making the opinions you intend to give today you are not relying on any studies or articles on the pain a fetus might experience during an intact D&E procedure; isn't that right?

A. That is right. Such information is not available in the medical literature.

MS. PARKER: Your Honor, we would object to the qualifications of Dr. Anand in—as an anesthesiologist and as to fetal pain under Federal Rule of Evidence 702, because Dr. Anand does not have the knowledge, skill, experience, training or education to testify in these two areas.

As to anesthesia, by his own admission, Dr. Anand is not an expert. He does not practice in this area. He is not trained in this area, and he has not done research on the area of fetal anesthesia.

THE COURT: I have a question in that regard. The [1561] doctor has indicated that he believes himself to be an expert in the pharmacology of anesthetic drugs and not anesthesia, per se, because he is not a certified anesthesiologist.

What is the difference between those two?

THE WITNESS: Your Honor, all of my research has been focused on the effects of anesthetic and analgesic drugs during early life in the developing brain and in the stress responses.

I have authored many articles on that subject. In fact, for the last two board congresses of pediatric and neonatal intensive care, I was the chairman of the pharmacology track within those board congresses.

My area of research is well-recognized as seminal in the area of anesthetic analgesic drugs during early life.

MS. PARKER: We do not object to his testifying about the pharmacology of anesthetics. But to the extent he wants to provide testimony about the impact or effect as a result of an anesthetic procedure, we would object to that.

THE COURT: Counsel indicated he was being offered as an expert in the pharmacology of anesthetic drugs, fetal pain and fetal neurobiology. And your objection is to testimony as an anesthesiologist, which doesn't appear to me that is what he has been called to give; is that correct?

MS. NORONHA: That is correct, Your Honor.

THE COURT: All right.

[1562]

MS. KRASNOFF: As long as that is clear when he starts providing his opinions, because we believe his opinions go over to the general area of anesthesiology.

THE COURT: I am sure you will point that out to me.

MS. PARKER: As to fetal pain, Dr. Anand admits he has done no research and written no articles on fetal pain. He has testified about his expertise in pain and stress responses, but not fetal pain, in particular.

While we have no objections to his testifying about his research and the judgments he makes based on his research, we object to the characterization of that as fetal pain.

THE COURT: Okay. All right. Response?

MS. NORONHA: Your Honor, may I—

THE COURT: Do you wish to respond or ask any voir dire on that?

MS. NORONHA: May I ask further questions before responding?

[KANWALJETT S. ANAND, M.D.—DIRECT EXAMINATION CONTINUED]

BY MS. NORONHA:

Q. Dr. Anand, first of all, you had wanted to explain some testimony in your deposition on page 44. Would you like to do that now?

A. Yes, counsel. The reason why I said that is because my deposition was abnormal insomuch it was obtained by two different counsels, Amy Wigmore and Beth Parker. And so there [1563] was a considerable degree of repetition of questions. On page 44, I would refer to lines six through 23 where I have described that there is a considerable degree of overlap in what I do for Department of Pediatrics and the missions and goals of these other departments.

So if I have published papers that are focused on neonatal pharmacology or I have obtained grants for studies that are designed for neonatal pharmacology or neurobiology, the information in here, then those activities—

THE COURT: Slow down, please.

THE WITNESS: Sorry. I apologize. Then those activities are listed as part of those the other departments, as well. So all of my salary support comes from Department of Pediatrics, and that's where my primary allegiance and effort is directed.

As for these other adjunct departments, yes, I will occasion provide services, as and when requested by those department heads. It's not, you know—there is no way of sort of classifying person effort to this department or that department, because what I do for Department of Pediatrics also helps the teaching in the Departments of Anesthesiology and Pharmacology and Neurobiology.

BY MS. NORONHA:

Q. Doctor, you stated you haven't conducted any studies yourself on fetal pain recently. How are you then able to [1564] opine on the subject of fetal pain if you yourself have not conducted some of those studies?

A. I have maintained a scholarly interest in the area of fetal pain and the development of the pain system during early life. The first time that fetal pain ever came into consideration in the medical literature was an article that was published in November of 1987 in the New England Journal of Medicine, which was titled "Pain and its Effects in the Human Neonate and Fetus."

Since then, multiple other articles have focused on this area. And although I haven't designed any original research protocols, I have served as a reviewer for the publications and protocols that other people have submitted, either for publication to journal or for grant funding at the NIH level, and, therefore, continuing my interest in fetal pain.

I have also served as a member of the editorial board of Biology of the Neonate, which is a journal that is focused on fetal and neonatal physiology. And as a member of the editorial board, I frequently reviewed papers on fetal pain and fetal stress responses.

Q. Doctor, you have conducted studies yourself on the subject of pain in pre-term neonates, right?

A. That is correct. Even my current research is focused on premature neonates all the way from 23 weeks of gestation [1565] onwards. And I frequently participate in those research studies in the collection and interpretation of data related to pain in pre-term babies. Insomuch that the physiology of the fetus and the premature neonate may be different, but the patterns of physiological responses to pain are very similar in the pre-term neonate as they are in the fetus.

There is a considerable degree of overlap that I would like to postulate.

MS. NORONHA: Thank you, Doctor.

Your Honor, the only thing I would like to add is that Dr. Anand has been qualified as an expert in these three areas before Judge Casey in New York. And although Judge Kopf in Nebraska does not particularly qualify experts, he did hear Dr. Anand's testimony.

THE COURT: Thank you.

All right. Anything else?

MS. PARKER: Yes, Your Honor. I believe that counsel also wanted to certify him as an expert in fetal neurobiology, but I do not believe he testified during his direct on any expertise in the area of fetal neurobiology. And in fact, he's testified his expertise is in care of

children, critically ill children and pre-term neonates, which are quite different than fetuses.

THE COURT: That is correct. You haven't elicited any information that would lead me to qualify him in that area [1566] do you wish an opportunity to do so?

MS. NORONHA: Yes. Thank you, Your Honor.

BY MS. NORONHA:

Q. Dr. Anand, I believe you stated you were familiar with the development of the pain system in early life. Can you explain how that is applicable to the fetus?

A. Certainly. The pain system starts developing very early in gestation from about six or seven weeks of gestation.

MS. PARKER: Your Honor, I am sorry to object at this time, but it appears he is now going to start providing his opinion, and he has not yet been qualified. So we think it is inappropriate for him—

THE COURT: I think that is what she is trying to get at, correct? We need to determine first if he is qualified. He has not told us anything about his background in fetal neurobiology.

MS. NORONHA: That is correct, Your Honor.

BY MS. NORONHA:

Q. Go ahead, Doctor.

A. Therefore, I have looked at the development of the pain system and have synthesized the data pertaining to fetal development of the pain system. This also has a major context in terms of developing—

THE COURT: If I can stop you for a moment. Maybe you start at the beginning. What is neurobiology as it applies [1567] to fetuses?

THE WITNESS: Certainly, Your Honor. Neurobiology is the discipline for the study of the central and peripheral nervous system. The central nervous system comprising of the brain, the brain stem and the spinal cord. There is the peripheral nervous system, includes the nerve fibers and the receptors located in the skin, mucus membranes and other organs.

And that's the discipline of neurobiology.

THE COURT: How are studies conducted on fetuses?

THE WITNESS: There are different ways of looking at the neurobiology of the fetus. Primarily through animal experiments or through fetuses that were the result of abortions. And a lot of the early research was done on fetuses that were obtained during abortions.

So, those are some of the studies that I have reviewed. There are also current studies ongoing that look at physiological responses in the fetus when it is subjected to a painful stimulus or painful experience.

And I have served as reviewer for those studies. I have been invited to write editorials on the subject of fetal neurobiology. I have published several articles that deal with the development of the brain and the impact of pain on this development.

THE COURT: All right. So you have not conducted [1568] any of the studies yourself?

THE WITNESS: You're right. I have not conducted those studies myself.

THE COURT: All right. Anything else?

MS. NORONHA: I have nothing further, Your Honor.

THE COURT: All right. Anything else from you, Ms. Parker?

MS. PARKER: No, Your Honor.

THE COURT: All right. On the three areas in which he has been offered, I find that the plaintiffs' arguments pretty much go to the weight to be assessed and to be assigned to his testimony in this regard, more so than the qualifications. I will permit him to testify as an expert in all three areas.

MS. NORONHA: Thank you, Your Honor.

BY MS. NORONHA:

Q. Dr. Anand, I would like to turn now to the definition of pain. Would you please give us a definition of pain?

A. Pain is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

Q. Doctor, what is the source of that definition?

A. This is the official definition that was proposed by the International Association for the Study of Pain. They have a committee on taxonomy that decides the definition of various * * *.

* * * * *

[1572] to paralyze them, there will be the perception of pain, but there will be no reaction to pain, no behavioral reaction to pain, as such.

There are other situations, altered states of consciousness where there can be perception of pain, but no overt reaction to pain.

Q. Doctor, there is another note under the definition of pain that states that:

"Pain is always subjective."

What does that mean?

A. It means that pain has special meaning and significance for the living being that is experiencing the pain. It pertains to the subject that is undergoing that experience, the subject of that experience.

I would like to add, if I may, that every experience, not only pain, is, in essence, a subjective experience. Even people who undergo the same experience have a very individual experience that is special to that individual.

So pain, as well as all other experiences, are entirely subjective.

Q. Doctor, now, I would like to turn to fetal pain. Do you have an opinion as to whether the fetus feels pain?

A. Based on multiple lines of evidence I believe that fetuses beyond 20 weeks of gestation have the ability to feel pain.

Q. Could you generally tell us what you mean by "multiple * * *.

* * * * *

[1585]

And other studies have looked at the sense of smell, for example. There was an experiment done

where pregnant women were asked to take a capsule, which was tasteless and odorless, but contained crushed cumin—cumin is a herb—within the capsule.

And after the babies were born, they were exposed to the scent of cumin versus the scent of citron, which a lemony scent versus another uncharacterized scent, and they had a calming and orienting response to the smell of cumin, so that it shows that there are different lines of evidence to show that the brain is actually functioning. It's doing something. And all these sensory systems are developing during fetal life.

Q. Doctor, now let's turn to the physiological indicators for pain that you mentioned. What does "physiological" mean?

A. "Physiological" pertains to changes in the physiology that may occur as a result of the response to pain. And these areas have mainly been looked at in terms of hormonal and circulatory responses to pain.

Q. Are their studies that have shown these hormonal and circulatory responses to pain?

A. Yes. There is a consistent and well-developed line of investigation followed for the last 10 or 15 years that has shown consistent responses with the release of hormones and changes in circulation in response to painful stimulation.

Q. And how early have these responses been exhibited in the [1586] fetus?

A. The earliest response that has been reported in the literature is from about a fetus of 16 weeks of gestation. But most of these responses are robust and reproducible after 20 weeks of gestation.

Q. Doctor, would you describe briefly for us the study performed on stress hormones?

A. Certainly. One of the leading researchers in this field is someone by the name of Dr. Nicholas Fisk from Imperial College, London.

And he has published several studies where fetuses who required a blood transfusion in utero were given the blood transfusion using two different approaches. One approach is to give the blood transfusion at the insertion of the umbilical cord where you can advance the needle into the umbilical vein and give a fetal blood transfusion to the fetus.

In some situations if the fetus is positioned in a way that the fetus seems to be covering the placenta, then access to that area is limited or is impossible. And so an alternative method is to introduce the needle through the abdominal wall, through the fetal body into the abdominal wall, across the peritoneal cavity into the capsule of the liver. And then place the needle in a vein that lies within the liver. It's called the intrahepatic, and to transfuse through that vein.

[1587]

When the responses of fetuses are compared between these two different approaches, one is a painful approach, the intrahepatic vein, and the other is a nonpainful approach, through the umbilical cord, because the umbilical cord doesn't have any sensory nerves.

What they found were robust hormonal responses that occurred as a result of transfusion through the intrahepatic vein. These hormonal responses were characterized by measuring levels of beta endorphin and found five to sixfold increases in this hormone,

characterized by the release of catecholamines, horones such as adrenalin and noradrenaline, and up to two or threefold increases occurred. And the release of cortisol, which is another stress hormone released. And this was released in response to the painful approach using the intrahepatic vein.

What was also remarkable was that the magnitude of this hormonal response was directly correlated with the duration of painful stimulation. So not only is the fetus able to respond to pain, but can respond to different durations of the painful stimulus.

Q. Doctor, you mentioned there was also a study performed a circulatory stress responses. Would you briefly describe that study, please?

A. Certainly. Several studies have looked at circulatory responses in the fetus and primarily have seen changes in blood [1588] flow to the brain that result during a painful stimulus. For example, there is a decrease in what is called the pulsatility index of the middle cerebral artery. This is an artery that supplies the sensory area of the brain, and which implies that following painful stimulation an increase in blood flow occurs to that part of the brain.

And this response was noted within 70 seconds of the needle piercing through the fetal abdominal wall.

Q. Doctor, was there any anesthesia used in either of these studies?

A. Initial studies were done without any anesthetic being administered to the fetus. These studies were performed under ultrasound guidance. And one of the later studies published, I believe in October 2001, decided to test the hypothesis that: Is this a specific pain response?

So what they did was they—for fetuses that were having repeated transfusions they randomized them to either receive fentanyl, which a pain relieving drug—spelled F-E-N-T-A-N-Y-L—a pain relieving drug was given at the beginning of the transfusion, and then the transfusion was given, and then the hormonal response was measured. As opposed to the same fetus receiving the blood transfusion without the fentanyl.

And what they found was giving the anesthetic drug blocked the hormonal and the circulatory response to the [1589] painful stimulation during blood transfusion.

Q. Doctor, are there any other factors besides pain that can cause these stress responses?

A. That is a good question. The stress response is primarily not specific, so that other things, for example, if the mother gets a fever and the fetus has a fever, that will also lead to a stress response.

But the fact that these responses are sequentially and temporally related to painful stimulation, really substantiates the fact that these are in response to a painful stimulus.

Also these researchers have been very careful about studying the control situation as well. For example, they will measure the hormonal levels at baseline, and then they will measure the hormonal level after the painful stimulus has occurred.

And in some fetuses they will use the painful method through the intrahepatic vein versus a non-painful method, through the umbilical cord.

So good controls help us judge that these are responses specific to the painful stimulation.

Q. But, Doctor, would you say that these physiological responses are direct evidence of pain in the fetus?

A. It depends on what you want to classify as "direct." Essentially, the fetus cannot talk. And if the fetus can't [1590] talk to us, then we need to find other surrogate markers for the response of the fetus. And we're simply limited to the changes in physiology or changes in behavior that would result following painful stimulation.

Q. Would you characterize these responses as an inference?

A. Yes, to a great extent. The pattern of these responses is very similar to the pattern of physiological responses that are generated in older children or adults.

And older children and adults are able to tell us that they have perceived pain. So we look at the pattern of responses, even though there are huge physiological differences between a child and a fetus, however, the pattern of the response appears to be very similar. And the child does report that this is painful.

So, we can infer from these studies that these may be reaction to the pain that the fetus was experiencing.

MS. NORONHA: Your Honor, I understand that you break at 10:00 o'clock. Would you like to do it now?

THE COURT: Is this a good place for you?

MS. NORONHA: Yes.

THE COURT: All right. We will break for 15 minutes.

THE WITNESS: Thank you, Your Honor.

(Recess taken at 10:00 a.m.)

(Proceedings resumed at 10:18 a.m.)

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[1593]

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Q. And, doctor, aren't there differences between premature neonates and fetuses that would affect your ability to extrapolate from one to the other?

A. There are certainly differences, physiological differences, between a fetus and premature neonate, even at the same gestation.

The fetus does not require the ability to get oxygen and nutrition and so on. All these are supplied to the fetus through the umbilical cord from the maternal side. Whereas, a premature infant has to resort to its own physiology in order to maintain oxygenation through the lungs and the heart or has to deal with alternate periods of feeding and fasting, which is not the case during the fetal life. There is a continuous supply of nutrition through the placenta.

So there are major physiological differences between fetuses and premature infants.

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[1606]

I believe at that time a surgical incision is placed and a trocar is inserted to puncture through the occipital bone and the membranes covering the brain,

and then suction is applied to simply remove the intracranial contents. And then the fetal head is delivered through the cervix.

That's my somewhat rudimentary understanding of this procedure.

Q. Doctor, do you have an opinion as to whether this procedure would cause pain to the fetus at or beyond 20 weeks' gestation?

A. Yes. If performed on fetuses beyond 20 weeks of gestation, this procedure has a very high probability of causing prolonged and excruciating pain to the fetus.

Q. What do you mean by "prolonged and excruciating pain"?

A. I believe that the grasping of the lower extremity of the fetus, the manipulation of the fetus and its —the delivery of the fetal body through an incompletely dilated cervix would be traumatic and painful to the fetus.

That the surgical incision placed would cause acute pain, because of the tissue injury involved. That the puncture through the occipital bone, through the membranes of the brain, both of which are very richly innervated with sensory fibers would cause excruciating pain.

Up to the point that the fetal brain is suctioned out and fetal demise occurs, there would be pain experienced by the fetus.

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[1614]

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Q. On direct, Dr. Anand, you testified that you believe a fetus experiences pain at 20 weeks' gestation; is that correct?

A. That is correct.

Q. And you are measuring 20 weeks as 20 weeks after conception; is that correct?

A. That's correct.

Q. That would be approximately two weeks later than 20 weeks LMP?

A. That is correct. Pregnancy begins at conception, I believe.

Q. So it is either 20 weeks after conception or 22 weeks LMP?

A. That is correct.

[1615]

Q. Now, I believe your testimony was that there were converging lines of evidence that suggests that consciousness in the fetus occurs at about 20 to 22 weeks; is that right?

A. That is correct.

Q. But you do not hold the view to a reasonable degree of certainty that fetuses before 20 weeks experience pain?

A. That is correct.

Q. In fact, you are not at all certain that a fetus can experience pain between 16 and 20 weeks?

A. That is correct.

Q. At your deposition you said there is only a 50 percent probability that a fetus can feel pain between 16 and 20 weeks?

A. Exactly. The likelihood of feeling pain or not feeling pain is about the same. There is—so, at this point I am not able to say either way does the fetus feel pain or does not feel pain between 16 and 20 weeks, like you said.

Q. It is no different than we flipped a coin, 50 percent heads/50 percent tails?

A. You're right. Absolutely.

Q. And, indeed, your opinion with respect to the fetus between 16 and 20 weeks is based on a new view of pain?

A. That is ~~correct.~~ —

Q. A very novel, new view?

A. Absolutely right.

Q. In fact, no one has done a study of that new view as it [1616] relates to fetuses?

A. That is correct.

Q. And no one has ever done a study of the new view of pain as it relates to pre-term neonates?

A. You're absolutely right. This is a very novel view of pain that was published as recently as June of 2003. And currently, there are no studies that have been published based on this new view of pain.

Q. And is there no firm scientific evidence that pain can be experienced by a fetus as early as 16 weeks?

A. No, there is not.

Q. Or, indeed, before 20 weeks?

A. No, there is not. I agree that there is some data showing physiological responses, meaning release of hormones or changes in circulation before 20 weeks, but I am very skeptical about the reproducibility of that data and feel that it cannot—it cannot be relied upon as well or as much as we can rely on data after 20 weeks of gestation.

Q. And that is why the majority of scientists agree that there's no—that pain cannot be experienced before 20 weeks?

A. I agree with that, yes.

Q. And so it would not be a medical fact that a fetus would experience pain before 20 weeks?

A. That is correct.

Q. Now, Dr. Anand, on direct you offered an opinion that a [1617] fetus would be subjected to pain from the abortion procedures banned by the partial-birth abortion ban act of 2003; is that right?

A. That is correct, if the fetus is beyond 20 weeks of gestation.

Q. Okay. So your opinion does not go beyond the 20 week period?

A. That is correct.

Q. So if there are procedures that are banned by the act before—that occur before 20 weeks, your opinion does not apply to those procedures?

A. Absolutely right.

THE COURT: Let me make sure I understand. When you use 20 weeks, we are talking about 22 weeks LMP?

MS. PARKER: That's correct. That's what he—

BY MS. PARKER:

Q. That is what you testified. You are talking about 22 weeks LMP?

A. I testified that it's 20 weeks of gestation or 20 weeks postconception—

THE COURT: All right. But you have—

THE WITNESS: —So it is—

THE COURT: Throughout this entire trial we have been using LMP. I want to make sure that I understand your testimony to be after conception. LMP would be an older—

[1618]

THE WITNESS: That's correct, Your Honor. Yes.

BY MS. PARKER:

Q. And by that your opinion starts at 22 weeks LMP; is that right?

A. Yes. If you postulate, which I haven't testified to, if you postulate, there is two weeks between LMP and conception. And that can be variable to some extent, but LMP is the accepted way in obstetric clinical practice of measuring the length of pregnancy, whereas in scientific studies involving fetuses or in the measurement of neonatal maturity of premature neonates, usually postconception is the usual way this is measured.

Q. Now, I would like to focus on your opinion that fetal pain can be experienced at 20 weeks LMP. It is

true, is it not, that there are no studies of fetal pain during an abortion procedure?

A. You're right. There are no studies that I know of that have looked at the question of fetal pain during an abortion procedure.

Q. And you're aware of no articles that are focused on that issue, either; isn't that right?

A. That is right.

Q. And, in fact, none of the studies you are relying on directly establish fetal pain at 22 weeks LMP?

A. That's right.

[1619]

Q. Your opinions are based instead—I think you said this on direct—on extrapolations from studies on premature babies?

A. Yes.

Q. And extrapolations from animal models?

A. Yes, as well as the responses of fetuses undergoing painful procedures in utero.

Q. And your opinion is also based on inferences?

A. That's correct.

Q. In fact, your entire opinion is based on inferences?

A. That is correct. All scientific conclusions are, for the most part, based on inferences.

Q. So as a result, it is not your opinion that a fetus at 22 weeks LMP will definitely experience pain?

A. It depends on how you define "definitely." It depends on what level of certainty that you consider as labeling definitely evidence.

Q. Well, in fact, at your deposition I think you used 80 percent was the number that you threw out?

A. Yes. In my deposition I had said that there is an 80 percent or greater probability that a fetus will experience pain during the D&X procedure after 20 weeks of gestation.

And that is simply to retain some level of scientific skepticism. I am prepared to discard my hypothesis if evidence shows to the contrary that a fetus does not feel pain after 20 weeks of gestation.

[1620]

Q. But that evidence does not—has not yes been tested.

There has been no definitive studies on that as of now; isn't that right?

A. You see, that's what I meant earlier. It depends on how you would—what you would take as definitive evidence. Pain or experience, for that matter, any experience cannot be measured directly except when it is reported by the individual undergoing the experience.

And so if you tell me what you consider as definitive evidence, then I'll bring out that evidence if it is available in the literature, or I will design a study to show you how that definitive evidence could be obtained.

Q. But studies looking at that directly today do not exist; isn't that right?

A. Certainly definitive evidence by direct measurement of fetal experience is not possible.

Q. Right. It is your opinion, is it not, that it is not possible to directly measure whether a fetus experiences pain?

A. That is right.

Q. No—

A. And that is why—that is why we depend on surrogate markers of pain and the multiple lines of evidence, the anatomical and physiological and functional and behavioral aspects of pain.

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[1622]

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Q. And it is true, is it not, that it's technologically impossible at this time to measure emotions of the fetus?

A. You're right. It is impossible to measure emotions in the fetus, although we are able to study the emotional responses of the fetus in the terms of facial expressions, eye blinking, or even the crying activity from movements of the diaphragm, using ultrasound behavior studies.

Q. Dr. Anand, if you could turn to page 128 of your deposition.

A. Yes, I have it.

Q. And it is true, is it not, I asked you at your deposition:

> "But you're saying you cannot evaluate the Emotional experience of pain by a fetus?"

And you responded:

> "At this time, I think it is technologically difficult to evaluate the emotional experience of the fetus. There are emotional experiences the fetus manifests that have been evaluated through studies in later pregnancy, so we do know that emotion does exist during fetal life."

And it is also your opinion we are just not smart enough to evaluate the emotional experience?

A. Yes. That is what is stated in the continuation of that [1623] statement.

Q. Right. Now, you also agree, I believe you stated on direct, with the IASP statement that pain is always subjective.

A. Yes, it is.

Q. By "subjective," you mean, it is meaning and interpretation by the individual who is experiencing it?

A. That is correct.

Q. And subjectivity cannot be studied in fetuses; isn't that correct?

A. That is correct, or at any other age.

Q. It cannot be studied because we cannot communicate with fetuses?

A. That is correct.

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[illegible6]

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Q. Okay. You would also agree that it is necessary for a fetus to have some level of consciousness in order to experience pain; isn't that right?

A. That is correct.

Q. And that is because you cannot experience pain without consciousness?

A. That is correct.

Q. And consciousness is not something that even can be [1627] measured in adults; isn't that right?

A. That is correct.

Q. And there are no studies examining consciousness of the fetus; is that right?

A. That is right.

Q. Those studies simply can't be done?

A. You're absolutely right.

Q. And you would agree, would you not, that there is no consensus in the medical community that consciousness begins even at 20 weeks for fetuses?

A. It depends on how you would define—in the general medical community, no, there is no consensus. But say, for example, people in our maternal fetal network who are very focused on the development during fetal life there would be consensus that consciousness is expressed very soon after 20 weeks of gestation.

Q. Well, didn't you rely in putting together your expert report on some articles that express the view there was no consensus that consciousness begins at 20 weeks?

A. Yes. Certainly I had included those in my expert report in—for due diligence, to show that there are contrary opinions to the one that I am stating.

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[1629]

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Q. If you could look at page 67, the right-hand column, the last sentence in the second paragraph, under the heading:

> "Consciousness in the fetus." Do you see that?

A. Yes.

Q. And there it says:

> "It may be impossible to obtain unequivocal Evidence for fetal consciousness"?

A. That is correct.

Q. And you're also familiar—I believe you discussed this on your direct—with a Royal College of Obstetrics and Gynecology in the United kingdom?

A. Yes.

Q. That organization had established a working group to review all of the material available at that time regarding fetal consciousness; isn't that right?

A. That is correct.

Q. And that group concluded that fetal consciousness did not occur before 26 weeks; isn't that right?

A. That is correct.

Q. So, the entire notion of fetal consciousness is fairly controversial; isn't that right?

[1630]

A. You are absolutely right.

Q. That is because there is no definitive evidence of it and when it begins?

A. Yes, that's correct.

Q. In your deposition you agreed with me it is all sort of supposition or speculation; isn't that right?

A. Where are you referring to in my deposition?

Q. If you can look at page 163, line 16 and 17. Actually, if you look starting at line 1, I asked:

> "Is it also controversial amongst the group of people who believe that there is fetal consciousness as to when that consciousness begins?"

And you answered:

> "True."

And later on I said:

> "There is no definitive evidence of it."

You answered:

> "Exactly."

I said:

> "So it is all sort of supposition or speculation?"

And you responded:

> "Exactly."

A. Yes, that is part of my answer.

* * * * *

[1633]

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Q. But there are physiological differences between pre-term neonates and fetuses?

A. I agree with you.

Q. And there are also radical differences in terms of their environmental experiences; isn't that right?

A. That is correct.

Q. And the studies you cited during your direct testimony about the ability of fetuses to acquire verbal memories, all of those were performed in the third-trimester; isn't that right?

A. They were mostly from the third-trimester. There were some studies from the second-trimester, as well.

Q. But none of those studies included fetuses at 20 weeks; isn't that right?

A. That is right.

Q. And to the extent that you express an opinion that there is consciousness in a fetus that would be a rudimentary form of consciousness?

A. That is correct. Consciousness, the prevalent notion in the medical community is that consciousness is not an all-or-none phenomenon. It is not like an on/off switch: on one minute and off the next, or vice versa. It is more like a [1634] dimmer switch.

It is more like the expression of consciousness is gradual. If I could use a common experience that we all have, when we awaken from a deep, dreamless state of sleep, there are intermediate levels of consciousness:

deep drowsiness, and then drowsiness, and then light drowsiness, and then awakefulness, and so on.

It is thought that consciousness appears in the fetus in a very similar manner that there are—after the development of the cortex is completed, there are increasing levels of consciousness very gradually. It is like the night meets the day. Very gradually there is the dawn of consciousness during fetal life.

Q. But it is your opinion, is it not, that to the extent a fetus has consciousness at 20 weeks it is rudimentary?

A. True. That is correct.

Q. Now, Dr. Anand, you also agree there is a difference in the medical—opinion in the medical community about the ability of a fetus to experience pain?

A. Yes, there are differences of opinion within the medical community.

Q. Even for those who feel or believe that a fetus could experience pain, there is disagreement as to when that they would first begin to experience pain?

A. That is correct.

* * * * *

[1641]

Q. But, Dr. Anand, it is correct, is not it not, that you cited a whole number of articles with your expert report, many of which conclude that the anatomical structures are not in place until 26 weeks?

A. Yes, Ms. Parker, I mentioned that—

Q. And that—

A. —I felt that due diligence was required in order to show both sides of the controversy.

Q. And so that would indicate that there is a fair bit of controversy within the medical community as to when fetal pain could begin to exist?

A. I agree with you.

Q. Now, because there is no definitive evidence of pain, you use surrogate markers. I think that is your term?

A. Yes.

Q. And those surrogate markers indicate pain is based on studies on children and adults, in part.

A. In part, in children and adults, and also from premature infants. And there are some direct studies from the fetus, as well.

Q. I believe we talked about the differences between pre-term infants and fetuses. But you would also agree, would you not, that there are huge physiological differences between fetuses and adults?

A. Certainly there are differences in their physiology, but [1642] the patterns of response to pain are considered cross-development.

Q. But the physiological differences would impact the ability to extrapolate from studies on adults to fetuses; isn't that right?

A. Certainly.

Q. And there are also physiological differences between fetuses and children?

A. Yes, there are.

Q. And those physiological differences would also impact on your ability to extrapolate from studies on children to fetuses; isn't that right?

A. To some extent, yes, although not completely.

Q. And one of your surrogate markers is that the anatomical structures required for pain are in place at 22 weeks LMP?

A. That is correct.

Q. And you base that on an analysis of normal, healthy fetuses?

A. That is correct.

Q. But those same conclusions—and I believe you've stated this on your direct testimony—do not hold true for fetuses with various fetal anomalies?

A. If those anomalies involve the brain, spinal cord or sensory nerves, yes, they would not hold true for fetuses with anomalies.

[1643]

Q. You do not extend your opinion with fetuses with certain chromosomal abnormalities?

A. Yes, if those chromosomal abnormalities include anomalies of the spinal nervous system or the peripheral nervous system, yes.

Q. Your opinion does not apply to them?

A. That is true.

Q. Your opinion does not apply to fetuses that have abnormalities in brain structure?

A. That is correct.

Q. So, for example, you do not extend your conclusions to a fetus with hydrocephaly?

A. That is correct.

Q. Or trisomy 18?

A. That is correct.

Q. Or trisomy 13?

A. That's correct. These are all lethal abnormalities of a chromosomal nature.

Q. Your opinion does not apply to them?

A. True.

* * * * *

[1651]

* * * * *

Q. And if you look at page 145 in the last paragraph?

A. Yes.

Q. That article concludes, does it not, that:

> "Indirect methods of assessing pain like motor movement patterns, pulse rate and blood pressure are still being developed and none is yet suitable for assessing pain in fetuses."

Isn't that right?

A. That is correct on page 146, the first paragraph.

Q. And, finally, you relied on an article by Fisk, which is Learned Treatise A-16.

MS. PARKER: May I approach the witness, Your Honor?

THE COURT: Yes.

BY MS. PARKER:

Q. That's an article titled "Effect of Direct Fetal Opioid Analgesia on Fetal Hormonal and Hemodynamic

Stress Response to Intrauterine Needling" that appeared 2001 in a journal called Anesthesiology?

A. Yes, I have it.

Q. I believe you stated on direct that Dr. Fisk was one of the leading researchers in the area of fetal response to hormonal stress; isn't that right?

A. Certainly.

Q. There, the authors in the article conclude it is not known [1652] whether the human fetus experiences pain; isn't that right?

A. Where are you reading?

Q. If you can turn to page 14 of 17, in the third paragraph, and the first sentence states:

> "Although the human fetus in the last half of gestation has the necessary neuroconnections for nociception, it is not known whether the human fetus experiences pain."

Do you see that?

A. Yes. That is correct.

Q. They also concluded, do they not, and I am looking at the final sentence of the third paragraph on page 14:

> "Because the relation between stress responses and pain is not clear, it is not possible from our data to conclude that the human fetus experiences pain in utero."

Do you see that?

A. Yes, I do.

* * * * *

[1656]

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Q. If you could look at section 4.1, the third and fourth sentences state:

> "Much public concern has arisen because of the possibility that a fetus may feel pain; such a possibility is founded on the existence of reflex movements and neural activity produced by sensory stimulation. Despite the usefulness of such reflexes in understanding spinal cord and brain stem pain processing, it would be a mistake to equate them with true pain experience which must involve the cortex and develop postnatally along with memory, anxiety, and other cognitive brain functions."

Do you see that?

A. Yes, I do. That is part of this report.

Q. And the MRC report also concludes that fetal pain is still poorly understood; isn't that right?

A. That is right.

Q. And if I could direct your attention to page 11, or section 9, conclusions. And there it states:

> "The basic molecular and cellular mechanisms of fetal and neonatal pain are still poorly understood as are the effects of anesthetics or analgesics." Correct?

[1657]

A. That is correct.

Q. Yes?

A. Yes. This report was published in August of 2001 and appeared before the paper by Nicholas Fisk and published actually a few months later.

Q. So, let's talk briefly about the effect of maternal anesthesia on the fetus, because I believe one of the opinions you gave concerned the effect of maternal anesthesia on the fetus; is that right?

A. That is correct.

Q. And I believe you stated earlier that you personally have not conducted any studies measuring the effects of anesthesia on fetuses?

A. Yes. My opinion is that it would be unethical to perform such studies because of the toxicity that the mother would be exposed to. So, no IRB committee would approve such research protocols.

Q. You have not personally done any obstetric administration of anesthetics either; isn't that right?

A. I have not. That's right.

Q. And it's correct, isn't it, that the effect of maternal anesthesia on the second-trimester fetuses is a relatively underinvestigated area?

A. That is correct.

Q. In fact, it is completely unexplored; isn't that right?

[1658]

A. To a great extent, yes, it is.

Q. There's simply no information of the delivery and efficacy of anesthesia to fetuses during the second-trimester that's currently available?

A. I wouldn't say that there is no information. There are studies that have looked at the medical termination of pregnancy using prostaglandins that have measured blood levels of anesthetics in the mother and the fetus, and there are some of those studies were performed in the second-trimester.

But the amount of data that is available is extremely sparse, extremely limited as compared to what is available in the third trimester or the first trimester.

Q. Dr. Anand, could you turn to page 179 of your deposition?

A. I have it.

Q. At lines 13 to 17, isn't it true that I asked you:

> "So, to date, there has been virtually no research addressing the sort of delivery and efficacy of anesthesia to fetuses during the second trimester?"

And you responded:

> "Yes, there is unfortunately no information on that."

A. That is correct. Although, since then, I am a little better informed about the information on—in this area. Also elsewhere I had stated that this is relatively * * *.

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[1660]

* * * * *

Q. Now, in forming your opinions about the effects of anesthesia, you assume that methods of local anes-

thesia would be routinely applied for intact D&E procedures?

A. Yes. That is what I have learned from reading the literature, particularly the work published by David Grimes and others in this field.

Q. But you have never yourself performed an intact D&E?

A. Certainly not.

Q. Or observed one?

A. Certainly not.

Q. So you don't really have any basis for knowing what methods of anesthesia are routinely applied in intact D&E procedures?

A. That is correct. I don't claim to be an expert in this area.

* * * * *

[1666]

* * * * *

Q. So, the opinions you've given about fetal pain focus on the intact D&E procedures that are banned by the act; is that right?

A. That is right.

Q. And you would agree, would you not, that to the extent of the fetus has the ability to experience pain during an abortion procedure, that intact D&E procedure would not be the only abortion procedure that might cause pain?

A. That is correct.

Q. You are familiar, are you not, with a method of abortion called induction?

A. To some extent. My understanding is rudimentary given the lack of expertise in that area.

Q. But it is your opinion, is it not, that a fetus may [1667] experience pain during an induction abortion procedure?

A. I mentioned earlier that if there is separation of the placenta and fetal demise occurs prior to extraction of the fetus, then there will be no experience of pain.

On the other hand, if the fetal demise does not occur, there would be the extraction of the fetus through an incompletely dilated cervix would be associated with pain to the fetus.

Q. And it's also your opinion, is it not, that a fetus would experience acute pain in reaction to needling for the purpose of injecting either digoxin or potassium chloride?

A. Yes, that is correct.

Q. And that the injection of digoxin or potassium chloride into the fetal body will certainly cause pain to the fetus?

A. Yes. From the point of entry of the needle into the fetal body to the point when fetal demise occurs as a result of cardiac arrest, there would be a brief period of acute pain.

Q. And it's also your opinion, is it not, that a fetus undergoing dismemberment during the abortion procedure that is known as the disarticulation D&E would also experience pain if it was more than 20 weeks out gestation?

A. Yes, that is correct.

Q. Indeed, severe pain?

A. Yes, depending on the degree of somatic injury that is involved, there is the likelihood of severe pain.

[1668]

Q. In fact, it's your opinion that a fetus undergoing a dismemberment procedure would experience greater pain than if the fetus were removed intact during an intact D&E procedure?

A. Up until the point that fetal demise occurs, yes, dismemberment will be associated with severe pain and may well be greater than what occurs during the intact D&E or the D&X procedure.

* * * * *

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

No. 4:03CV3385

LEROY CARHART, MD, WILLIAM G. FITZHUGH, MD, WILLIAM H. KNORR, MD, AND JILL L. VIBHAKAR, MD,
PLAINTIFFS

v.

JOHN ASHCROFT, IN HIS OFFICIAL CAPACITY AS ATTORNEY GENERAL OF THE UNITED STATES,
DEFENDANT

DEPOSITION OF
JOANNA M. CAIN, M.D.
Feb. 10, 2004

REDACTED

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* * * * *

[COPPOLINO EXAMINES CAIN]

* * * * *

[7] Joanna M. Cain was called as a witness and, having first been duly sworn, was examined and testified as follows:

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[13]

* * * * *

Q. [REDACTED]

A. [REDACTED]

Q. [REDACTED]

A. [REDACTED]

Q. [REDACTED]

A. [REDACTED]

* * * * *

[14]

* * * * *

Q. [REDACTED]

A. [REDACTED]

Q. [REDACTED]

A. [REDACTED]

Q. [REDACTED]

A. [REDACTED]

Q. [REDACTED]

A. [REDACTED]

* * * * *

[22]

* * * * *

Q. [REDACTED]

A. [REDACTED]

Q. [REDACTED]

A. [REDACTED]

* * * * *

[25]

* * * * *

Q. [REDACTED]

A. [REDACTED]

* * * * *

[67]

* * * * *

Q. [REDACTED]

A. [REDACTED]

Q. [REDACTED]

A. [REDACTED]

Q. [REDACTED]

A. [REDACTED]

* * * * *

[160]

* * * * *

Q. Okay. That topic terminology, what was discussed with respect to the issue of terminology?

A. As I indicated, in the materials the partial-birth abortion terminology was not considered a part of the medical lexicon. There was no clear definition of the term "partial birth abortion." One of the goals of the task force was to identify a specific definition that did not encompass other obstetrical procedures. Another goal was to identify an appropriate name for the procedure.

* * * * *

[164]

* * * * *

Q. My question is really, Exhibit 3 describes a definition of intact D&X that ACOG developed as containing all of the following four elements, and it lists those elements, "deliberate dilation of the cervix, usually over a sequence of days; instrumental conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus."

And the statement says "Because these elements are a part of established obstetric techniques, it must be emphasized that unless all four elements are present in sequence, the procedure is not an intact D&X."

[165]

Now, first question, did the task force come up with this formulation that I've just read?

A. Yes.

Q. And did the task force conclude that it was necessary that all four elements must be present in sequence, or the procedure is not an intact D&X?

A. Yes.

Q. Why would—I may be misunderstanding it, so I just want to ask you this question so I understand what the task force has done here. Why would a procedure not be an intact D&X if the fetus was already in a breech position?

A. The committee at that time was concerned that a procedure was being described that included instru-

mental conversion of the fetus to a footling breech and, because that was a significant part of the description, felt that it should be included in that way.

Q. If all of the other elements were present except the fetus was not converted to a footling breech by means of instrumentation, would you say that the procedure preformed was not an intact D&X?

[166]

A. By the description of this statement, then yes, it would not be an intact D&X.

* * * * *

[174]

* * * * *

Q. Did the task force find that the intact D&X procedure was, in fact, performed in the second trimester?

A. The task force focused on previability abortion, primarily in the second trimester.

Q. Did the task force find that the intact [175] D&X procedure was performed in the second trimester?

A. That is correct.

Q. Dr.—

A. Primarily in the second trimester.

* * * * *

[177]

Q. And the task force understood, did it not, that this procedure was performed beginning at 18 weeks, the intact D&X procedure?

A. That it could be preformed starting at 16 weeks.

Q. Did it have an understanding that it was being performed starting at 18 weeks?

A. The task force understood that intact D&X was one method of performing an abortion after 16 weeks.

Q. What did the task force discuss with respect to safety?

A. Numerous examples were raised by the members of the task force regarding different procedures in specific cases and issues of safety.

For example, in GYN-oncology, the most pertinent example would be triploidy, which is a form of cancer of the placenta often diagnosed in the second trimester with severe preeclampsia. In that case, that least amount of instrumentation possible of the uterine wall is desirable. So it is much safer for the woman to have an intact D&X to remove the molar pregnancy. So multiple examples were used to explore issues of safety at the time and in [178] comparison to other procedures.

* * * * *

Q. Okay. And you mentioned the CDC data. What was it about the CDC data which informed the task force's view with respect to the safety of [179] intact D&X?

A. The overall safety in the second trimester.

Q. Of D&E?

A. D&E, because D&X was not separately coded.

* * * * *

[190]

Was that the conclusion of the select panel?

A. That it was the only option?

Q. Well, if you want to look at Exhibit 7—I'll go a little above that. "Terminating a pregnancy is indicated in some circumstances to save the life or preserve the health of the mother." This was, obviously, a conclusion of the select panel; is that correct?

A. That is correct, and we could identify numerous circumstances in which this might be the best procedure for that, rare but still numerous.

Q. Where does it say in this statement that this would be the best procedure to do that? Would you agree with me it doesn't say in this statement that it might be the best procedure in some circumstances?

A. Right. Dr. Frigoletto and I discussed that, actually, on Saturday, because the amended final statement, which includes the executive committee statement, does include a sentence between the sentence you read and notwithstanding this [191] conclusion, "ACOG strongly believes that decisions about medical treatment must be made by the doctor in consultation with the patient." And both of us agreed that it was clearly the sense of the committee. We just thought it spoke for itself and that we were glad that the executive board had put that phrase in.

Q. I want to ask you about that in a second, but I just want to confirm that the sentence that "a select panel could identify no circumstances under which this procedure would be the only option to save the life or preserve the health of the woman," was that the conclusion of the select panel as reflected in this document?

A. Correct.

Q. Now let's talk about the added sentence. This is in the final statement, and you can look at Exhibit 3, if you'd like to have it in front of you.

A. I have 4.

Q. It's the same thing. The final statement approved by the board, a sentence is added, "an intact D&X, however, may be the best or most [192] appropriate procedure in a particular circumstance to save the life or preserve the health of a woman." And to complete the sentence, "and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision."

Who added that sentence?

A. The executive board edited the sentence.

Q. Were you a part of the deliberations in adding that?

A. No, I was not.

Q. Was this additional sentence presented to the task force for its consideration?

A. No, although it was very much in the sense of a discussion of the task force.

Q. Do you have any knowledge of the deliberations that resulted in the addition of this sentence?

A. I have information from Dr. Frigoletto about his recollections and also from Dr. Hale.

Q. And was it Dr. Frigoletto that proposed adding the sentence?

[193]

A. I don't believe that Dr. Frigoletto—I know that Dr. Frigoletto could not remember who proposed the sentence.

Q. Have you—other than Dr. Frigoletto—you said you discussed how this sentence came to be added with Dr. Frigoletto?

A. That's correct.

Q. And did you discuss it with Dr. Hale?

A. Not specifically with Dr. Hale, but I'm aware of his memory.

Q. Was there any debate at the task force over this sentence?

A. I don't remember this sentence coming up.

Q. Was anyone—do you know if anyone in particular was an advocate for adding this sentence?

A. I don't remember this sentence coming up at the task force meeting.

Q. Do you know if he was an advocate at the board for adding this sentence?

A. I don't know.

Q. Do you know if Dr. Hale was an advocate at the board for adding this sentence?

[195]

* * * * *

Q. Are you aware of any analysis or study—let's strike that and say, are you aware of any study which supports the conclusion that intact D&X may be the

best or most appropriate procedure in certain circumstances?

A. I'm not aware of a study. I am well aware of multiple circumstances that an expert panel could identify at the time of the task force where it was clearly the best choice, including in my field, where the other options led to a higher likelihood of death or recurrence of disease.

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[199]

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Q. **[REDACTED]**

A. **[REDACTED]**

* * * * *

[200]

* * * * *

Q. **[REDACTED]**

A. **[REDACTED]**

Q. **[REDACTED]**

A. **[REDACTED]**

[REDACTED]

Q. **[REDACTED]** [201] **[REDACTED]**

A. **[REDACTED]**

* * * * *

Q. **[REDACTED]**

A. **[REDACTED]**

* * * * *

[205]

* * * * *

Q. [REDACTED]

A. [REDACTED]

Q. [REDACTED]

A. [REDACTED]

* * * * *

[208]

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Q. Did he ever say—did you ever hear him say that—when he was asked—when asked why the statement said the procedure may be the best in some cases, do you know it to be Dr. Frigoletto's views that it may not be?

A. I think that was the view of all of us if it's interpreted in the sense that it is an individual decision for an individual patient with the circumstances of her disease process, her needs, and her risks, so that any procedure that may be appropriate for a diagnosis may be appropriate for some and not for others, even though the data on safety is the same between two procedures. Medicine is a highly individualized practice.

* * * * *

[232]

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Q. Okay. And what are some aspects of the D&X procedure that might lead a physician to conclude that a D&X is the best or most appropriate abortion procedure to save the life or preserve the health of a woman?

A. One of the elements that came up among the different and numerous examples was the decreased instrumentation and the ability to preserve a relatively intact fetus for evaluation, particularly for some genetic based congenital anomalies.

Q. And why would less instrumentation be beneficial?

A. It depends on the circumstance. In the circumstance of septic abortions, any increase in instrumentation might increase the ability of bacteria to enter the blood stream.

In the case of tropoblastic disease, increased instrumentation is likely to transport tropoblastic disease, which is a form of cancer to [233] other areas such as the lung.

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[234]

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Q. If I represent to you that Congress claims that an ethical consensus exists that the practice of partial-birth abortion "is a gruesome and inhumane procedure that should be prohibited," as a member of the ACOG task force on partial-birth abortion, do you believe there's such an ethical consensus?

A. No.

* * * * *

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C 03-4872 PJH

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., AND PLANNED PARENTHOOD GOLDEN GATE, PLAINTIFFS

v.

JOHN ASHCROFT, ATTORNEY GENERAL OF THE UNITED STATES, IN HIS OFFICIAL CAPACITY, DEFENDANT

DEPOSITION OF
STEVEN L. CLARK, M.D.
Feb. 12, 2004

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[PARKER EXAMINES CLARK]

[12]

A. Yes, but not elective abortion.

Q. Was that by choice or was that part of the required curriculum?

A. It was—well, that's—I guess that's two questions.

Q. Sorry.

A. There was an option that one could have trained in performance of elective abortions. It was not a required part of the curriculum. And it was my choice that I opted for additional obstetrics training as opposed to that elective.

Q. So, you opted not to train in elective abortions even though it was offered at USC?

A. That's true.

Q. And did you—what form of training in abortions, then, did you take?

A. Well, there would be—I can think of three categories. One would be first trimester pregnancy losses, where the embryo had died or the mother was having a lot of bleeding. And I did literally hundreds—literally hundreds of those.

There then would have been a second category of older, second trimester fetuses where the fetus had died. And then there would be another category of both first and second trimester fetuses where there were * * *.

* * * * *

[14] Perinatal Center, which was a large referral center for Central and Southern Utah. Since 1990, I have been on the faculty of the University of Utah as a full professor of obstetrics and gynecology.

Let me also add one thing that I may have missed, and that is the final year of my fellowship I also held a position as assistant professor at USC.

So I've been—that's been my position since that time. And I've held some administrative positions up until—excuse me, up until about the year 2000 at Intermountain Health Care, which is a private teaching facility of the University of Utah School of Medicine.

Q. So when you joined the University of Utah Medical School in 1990, you joined as a full professor?

A. Yes.

Q. You had not served as an associate or any other form of professor before you joined as a full professor?

A. Oh, I'd been assistant professor at USC.

Q. But that was just for one year?

A. Yes.

Q. Is that normal, to attain full professorship after one year as an assistant professor?

A. I think it's not normal in general, but when you've got, as I think I did—you can look at the CV * * *.

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[16]

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Q. Okay. So your current position is a full professor at the University of Utah—

A. Yes.

Q. —is that correct? And what are your responsibilities in that position?

A. 50 percent of my time, plus a share of night call, involves direct hands-on patient care. And this would be virtually exclusively women with serious problems or potentially serious problems who are referred by another obstetrician for care.

Most of the remainder of that time is spent teaching, either in terms of formal didactic lecturing or what you might call clinical teaching, rounding with medical students, fellows and residents or allowing them to assist in the care of women with various [17] pregnancy-related problems.

Q. Do you currently provide abortions as part of the 50 percent of the time you do with patient care?

A. Sure.

Q. Up to what week?

A. Well, it's—there's no line. That is to say, when —if at any point we determine that the mother's life or health is at significant risk, starting at conception and ending at full term, and if the mother then chooses to end that pregnancy, we end it.

And that may be done by cesarean section at full term or it may be done by suction curettage in the first trimester by D&E. In the second trimester—by medical induction anytime in the second or third trimester.

So I don't really draw a distinction in that sense, because I'm not doing elective procedures. But if a pregnancy needs to be ended for the mother's health, then it is ended.

Q. Do you teach abortion procedures in your capacity as a professor?

A. Yes, but not—these health issues, in fact, are quite rare in American medicine. But certainly those situations in which they are necessary, I both lecture and teach the indications for them and then [18] would either do or assist the resident in doing, if you want to call abortion anything prior to viability, the abortion. Or if you want—or delivery beyond that time.

Q. Okay. So do you actually teach the methods of abortion? You indicated you taught indications. Do you also teach methods?

A. Sure. But what I'm trying to tell you is that's not a major—I mean, you have to teach residents when they're doing the procedure, but it's not as if I have formal—we do that as the cases arise only.

Q. So, you've just teaching it almost in observation or by example—

A. On the job.

Q. On the job. You've not doing any formal teaching of methods of abortion or techniques for abortions?

A. I don't lecture on techniques of abortion. Let's put it that way. But I teach, as I am performing such procedures in those unusual cases when they've necessary medically or for serious anomalies.

Q. Do you supervise others who perform elective abortions?

A. No.

[19]

Q. Are elective abortions done at the University of Utah?

A. No.

Q. Were elective abortions done at the University of Utah Regional Perinatal Center?

* * * * *

Q. Your resume indicates you were the chairman of the quality assurance committee here at—or the Department of OB/GYN at LDS Hospital.

A. Yes.

Q. How long have you held that position?

A. Well, I think since 1990.

Q. And what does that position entail?

A. There are certain fall-out criteria for bad outcomes for mother or babies which require a chart to be reviewed. And then I chair a committee which reviews those records and determines whether the care given was appropriate or inappropriate and then recommends appropriate training or disciplinary steps, if the care was deemed to be inappropriate.

* * * * *

[21]

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Q. Have you written any articles about abortion [22] procedures—

A. No.

Q. —or abortion techniques?

A. No.

* * * * *

Q. But you have no recollection of having conducted peer review on any articles involving abortion procedures or techniques?

A. That's true.

Q. Have you participated or conducted any studies of any method of abortion?

A. No.

* * * * *

[35] abortion?

A. Not that I can remember.

* * * * *

Q. So, what is the earliest period of time when you would think about doing a labor induction for the purposes of an abortion?

A. Well, I would currently probably not recommend it prior to 18. That is, the induction is usually much more difficult prior to that. And D&E would be—in most cases would be preferable, I think.

Q. You indicated a few moments ago that you have not done that many labor inductions for purposes of an abortion; is that right?

A. Yes, it is.

Q. Can you quantify that it any way? Are we talking under 20?

A. Yes.

Q. How about under ten?

A. I don't know about that.

Q. But definitely under 20. That's in your [36] career?

A. I think so, yes. The situations in which abortion is necessary to preserve the health of the mother are rare as hen's teeth. But they do, in fact, arise. But even in someone who focuses in critically ill mothers, as I do, and have transports from all around the Intermountain West for mothers who are sick, the number of times in which terminating that pregnancy will benefit the mother's health are so uncommon that that's where you get the numbers I have.

Q. Now, your report also states you're familiar with surgical abortion using dilation and evacuation, the D&E; is that correct?

A. Yes.

Q. What is the basis for your familiarity with the D&E procedure?

A. Well, I've done a handful. I think what I estimated is a dozen, maybe, something like that. This would be for later—later than a D&C.

Q. So, you've done approximately 12 D&E abortions?

A. That sound reasonable, sure.

Q. That's over the course of your career?

A. Yes.

Q. Could you describe the D&E procedure for us?

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Q. And you've indicated you've never done a D&E post 20 weeks.

A. I think that's true.

Q. And why is that?

A. Lack of experience and the availability of a medical technique.

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Q. So when you've done D&E abortions for non-elective reasons, what are the circumstances under which you've done them?

A. Well, the similar things, heart disease, hypertensive disease; cystic fibrosis—that is, maternal cystic fibrosis with severe pulmonary compromise; and then some anencephalics and other lethal anomalies.

Q. And do you know whether D&E is contraindicated for any of those conditions?

A. I know it is not.

Q. It is not contraindicated?

A. It is not contraindicated for any of those conditions.

[40]

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Q. Under what circumstances have you referred a patient for a later D&E?

A. Well, there have been—I can think of a couple times in 20 years when a later D&E was needed or later termination was needed but, for whatever reason, we didn't think that a medical—a medical termination was appropriate or perhaps the medical termination had failed or the mother chose, I think—you know, let me go back.

I can't ever think of a situation, actually, in which the medical induction was inappropriate. But there were some cases where the mother has chosen not to have a medical and she wants the surgical procedure, rather than go through the medical induction. I think those have been the primary times.

Q. And why has the mother chosen not to do a medical procedure in those situations that you just described?

A. She wants to be, I think, done with it quicker.

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THE WITNESS: Well, I think that's too broad. But the surgical procedure you're talking about, D&E, would always take substantially less time than a medical induction at the same gestational age.

Q. (BY MS. PARKER) And sometimes mothers prefer to go that route to have less time for the procedure?

MS. GOWAN: Objection.

THE WITNESS: Yes, that's true.

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[48]

So with that sort of expertise in ultrasound to grasp what one wants to grasp is a hundred times easier than the umbilical sample and those sorts of procedures.

Q. So is it your goal to do as few passes as possible with the instruments in a D&E procedure?

MS. GOWAN: Objection to form.

THE WITNESS: No, I wouldn't say that. No, the goal is simply to empty the uterus.

Q. (BY MS. PARKER) Do you see any benefit to doing it with as few passes as possible?

A. If you're—no, if you're good. If you've got the—if you're doing it under ultrasound guidance and you're a skilled sonographer, you simply will not place that forceps anyplace you cannot see.

If you're klutzing around in there or poking around blindly, well, sure. In fact, no passes would be best for a person like that. But if you're skilled and you've got ultrasound, you can see every second of the

procedure exactly where all the structures are that you do and do not want to approach, exactly where the forceps is and is not.

And even for me, who doesn't do very many of them, I can't see how you could possibly perforate. So as many passes as you want, as long as you don't [49] perforate, is not going to hurt. If you're doing it properly with the proper visualization, I don't really see the numbers of passes would be germane.

Q. Have you ever done a D&E procedure when the fetus's head has become stuck?

A. No.

Q. Have you ever heard of that happening?

A. Stuck? No. Usually, it's broken up by the forceps. And understand that at these little ages, stuck is a relative term. I mean, even in a full-term baby you're delivering breech in those situations where the head gets stuck, we're now talking a matter of three or four more minutes before the head is going to deliver. That's with an eight-pound baby.

So the head getting stuck on a small fetus is not very stuck. By the time you've got that out, the rest of the body out, a stuck head is a matter of minutes before a gentle extraction will expel it.

Q. Do you every use KCL for D&E abortions?

A. No.

Q. How about Digoxin?

A. No, not for that purpose.

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Q. (BY MS. PARKER) Other than reading articles by those two physicians, do you have any other basis for your understanding of the D&X method of abortion?

A. Well, of the technical procedure of the D&X; that is, the way these doctors do it, I can only take—I take it for granted that the way they say they do it, they do it.

Now, in terms of indications for it, sure. The entire understanding of maternal/fetal physiology, anatomy, maternal critical illness, and maternal not-so-critical illness would give me an understanding of when that procedure may be advantageous, when it may not be advantageous, assuming everything they say about the technical aspects of it are true. But in terms of how D&X doers do the D&X, I only have their descriptions.

Q. And when did you read their descriptions for the first time?

A. In conjunction with this case.

Q. You had not previously read those articles?

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Q. So it's limited to those two articles?

A. Yeah.

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Q. (BY MS. PARKER) And you, yourself, have never performed a D&X abortion?

A. Correct.

Q. And you've never seen one performed?

A. Correct.

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Q. Do you know whether the D&X method is taught in any medical schools?

A. No.

Q. Do you consider yourself skilled in the provision of abortion?

A. Only moderately.

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Q. (BY MS. PARKER) And how many babies do you deliver a year?

A. Well, I, myself, it depends upon the—what you're going to categorize. I probably deliver now 20 a year with my own hands. I probably deliver another 150 to 200 where my hands are over the hands of the resident or medical students. I'm right there supervising it. And I probably see 50 to 60 complex patients a week—pregnant patients. But in most cases the delivery is not the issue, so we leave that up to the private

doctor and I manage other aspects of pregnancy. So that is the spectrum.

Q. And approximately how many babies have you delivered in your career?

A. Well, when people ask me this, I say, More than 5,000, but less than 10,000, and that's about as good as I can do.

Q. Do you ever counsel patients about the abortion option?

[57]

A. Sure.

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[58]

A. Sure.

Q. If there's a conflict of interest between the pregnant woman and the fetus, your view is that the mother's interests are predominant in that conflict?

A. Well, from a medical standpoint. And I mean, you asked me once about—I'm not here to talk about social, ethical, moral things. More smarter people than I am can figure that out.

From a medical standpoint, yes. When there is a medical conflict and the medical interests of the mother differ from the medical interests of the fetus, the mother's medical interests must come first, if you can't satisfy both, which, fortunately, in the vast majority of cases, we can. But where both cannot be satisfied, it's axiomatic that the mother's medical interest must come first.

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Q. (BY MS. PARKER) So where there's significant health risks to the pregnancy, it's the patient's decision as to whether to terminate the pregnancy, made in consultation with the physician?

A. Yes.

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Q. Okay. Other than those abortions about which you've just testified and the different methods, have you ever observed different types of abortion methods being performed?

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THE WITNESS: No, not that I can think of.

Q. (BY MS. PARKER) I understand you're board certified in OB/GYN in maternal/fetal medicine.

A. Yes.

Q. Do you have any certification in performing abortions, specifically?

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[70] statute banned?

A. Well, sure. Yes, I did.

Q. And what was that opinion?

A. Well, the D&X procedure, as very specifically—the statute seemed very, very specific about what it banned and what it did not ban.

Q. So, is it your opinion that the statute only bans the D&X procedure that was outlined in the Haskell and McMahon articles?

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THE WITNESS: I think it's even more limited than that.

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Q. Exhibit 4 is now a copy of the act that's at issue in this case, which is before you, correct? And you indicated that you had formed an opinion as to what procedure this act covered—

A. Yes.

Q. —is that right?

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Q. (BY MS. PARKER) And could you tell us what that opinion is?

A. Yes. Well, you asked me what how it differed from the McMahon—from the procedures described by the MaMahon—

Q. Right.

A. —thing. Yeah. Well, the first thing is that, of course, the McMahon procedure would apply to [73] dead fetuses—could be applied to dead fetuses, as well as living fetuses. And this procedure clearly excludes dead fetuses. That is, this statute or law or whatever it is says nothing to do with dead fetuses.

Number two, I don't think McMahon claimed this, but I think some of your experts have claimed that by some amazing accident, maybe they're not trying to do—they're going in to do one procedure and, what do

you know, the next thing you know the whole baby is out except up to the head and they did it by accident.

Well, if that's actually true and people who do this by accident are doing these procedures, this would certainly not apply to that, because this talks about deliberately and intentionally vaginally delivers a living fetus, et cetera for the purpose of performing an overt act.

There was also—I think there were also some suggestions by some of the people who described this—I guess by your experts—that somehow this would prohibit maybe decompression—needle decompression of a child with hydrocephalus. But indeed, that would not apply, because in this case the statute applies to an overt act that you know will kill the partially delivered fetus. And simply decompressing cerebral spinal fluid for hydrocephalus, you cannot know [74] that will kill.

Many of these kids are born—are born alive. So by accident, by needle decompression or by—or a dead fetus, none of those things would—my reading of this statute would even come close to applying there. So this was more restricted. This only restricts a subset of partial-birth abortions performed intentionally on a live fetus.

Q. But do you read the statute to cover the D&X procedure that we've been speaking about the past hour?

A. For a living fetus intentionally, yes.

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[88] rather than risk tearing the cervix with over dilation in D&X or with the instruments used to punc-

ture or collapse the skull or suck out the brains. Do you see that?

A. I do.

Q. And is that your opinion?

A. Well, let's see. I think if you put a period after the word—after D&X. I wouldn't phrase it in those words, but I think it's not bad—not a bad try.

Q. So it's your opinion that it's always better to make another pass with an instrument, rather than risk tearing the cervix with over dilation?

MS. GOWAN: Object to the form of the question.

THE WITNESS: I said that conveys the general principle. The way my opinion would be—again, this is Ms. Gowan's words—that even if—I mean, the current data would not suggest the number of passes—there's no data that suggests the number of passes increases the risk.

And, in fact, the Jacot article showed that there was no increased risk of—actually, there were more perforations with suction D&C than there were with D&E where you're not passing grasping instruments at all into the uterus. So what data we have would suggest, in [89] fact, the risk of perforation is virtually nonexistent when appropriately done in any case and if—remember, that was an older article.

If you used modern methods and were visualizing with ultrasound, I don't see how you could possibly —how another pass could possibly—or another ten passes or another 30 passes could possibly be trouble, unless you don't know what you're doing. Because you simply should not make a pass unless you can see exactly where everything is and where you are.

On the other hand, we know that inappropriate types and degrees of mechanical cervical dilatation can predispose to preterm birth in subsequent pregnancies. I don't think anybody would deny that.

When you've got a procedure like this with Dr. Haskell where principle one is dilation and principle two, in giant capital letters, is more dilation, and you're dilating up to 75 percent of the BCB of the fetus, I would think you would have some pretty good data documenting the fact that these women do not have an increased risk of subsequent preterm birth before one could ethically subject a woman to an unproven procedure requiring this sort of dilatation when you've got a procedure whose incredible safety record has been documented for two decades. That would [90] be the way I would say it.

Q. (BY MS. PARKER) So, the procedure that you think has a good safety record is the D&E procedure?

A. Yeah, sure.

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MS. GOWAN: Where are we looking on the report here?

MS. PARKER: On page 3, Exhibit 6.

Q. (BY MS. PARKER) So the first opinion goes to the medical necessity of a D&X procedure. And you indicate on page 3 that, the changes to a woman's physiology as a result of pregnancy occur slowly and are [101] not resolved until some weeks after her pregnancy is concluded either through birth or abortion.

A. Yes.

Q. Do you see that? What do you mean by that statement?

A. Well, I understood from—I understand that there has been some allegations or some assertions that a D&X is safer because it can be done quicker.

Now, I also understand that this retrospective paper may show that may not be the case. But whether it is—let's say it can be done quicker. What I'm saying is there simply is no condition in pregnancy in which completing the expulsion of the fetus now as opposed to 30 minutes from now or one hour from now makes any difference whatsoever.

And so even if this were—if this were necessary to preserve the health of a mother, and if it were shown that this could be done on the average a few minutes quicker than a D&E procedure, that's trivial, in terms of any medical condition known to man, because neither health changes, physiologic changes, nor disease processes resolve with the delivery of the fetus.

In fact, in most cases the fetus is completely irrelevant to the risk to the pregnancy. It's the placenta and the hormones the placenta make [102] that are the problem. So ultimately, the problem for which you are doing the termination is not going to begin resolution until the placenta is delivered and then it's over one way or another. Those minutes potentially saved are not relevant to the medical care.

Q. You're making that statement in the context of comparing a D&X to the D&E method?

A. Yes.

Q. What about in comparison to induction method, which you testified earlier took considerably more time?

A. Well, I'm trying to think of a condition in which —clearly eight, ten hours is different than either of these procedures. That's a significantly longer period of time. Now, I'm having trouble thinking of it—I really can't think of an example in which even that length of time would matter.

Q. What about the example you gave earlier today when it was 36 or 48 hours was the length of time for an induction?

A. Still with assuming the rest of the medical care is appropriate, even in that extreme I can't right now think of a situation. But it's true that if you did that you might have to give less medicine or something.

So there are times when a D&E—I would say not very many, but when a D&E might be preferable [103] time-wise to a medical abortion. I can't think of any, but at least we're getting closer to some semblance of reality there. But D&E and versus this D&X, no.

Q. Further on in that paragraph you are stating, While there are many conditions that may place a woman's health at risk or her life in jeopardy, very few of these require immediate termination of a pregnancy.

A. Yes.

Q. Is it your opinion that there are some that may require immediate termination of a pregnancy?

A. Sure. "Immediate" being today or tomorrow, as opposed to next week or the week after, sure.

Q. What are those conditions?

A. The only one I can think of would be severe preeclampsia with either profound thrombo—different variances of severe preeclampsia. It might be—which, of course, is extremely rare prior to the third trimester, but can occur.

Q. And what—

A. And there a D&E—there's an example. I can't think I've encountered such a case in—that I can remember. But theoretically, there could be an example of a situation where there D&E might be preferable to an induction, if you were talking about a 22-, 23-week fetus from a time standpoint.

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[106]

A. You asked that as one of the very first questions this morning, and there's too many to—I gave you the same—I give you the same examples again, heart disease, lung disease.

Q. Well, you indicated on page 4 of your expert report, Exhibit 6, that there was some cardiac conditions.

A. Sure.

Q. What are those conditions? What cardiac conditions were you referring to when you mentioned them on page 4 of your report?

A. Well, there are, I mean, many. Let's start: Pulmonary hypertension of any etiology, aortic aneurisms, prior myocardial infarctions, severe valvular disease, potentially certain forms of lethal dysrhythmia, preexisting cardiomyopathy.

Q. And these are all cardiac conditions that may require termination of a pregnancy?

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THE WITNESS: Yes, they are, to preserve the health of the mother.

Q. (BY MS. PARKER) And your report refers specifically to peripartum cardiomyopathy; is that correct?

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Q. And are there any studies about the methods of abortion used in the circumstances of renal disease?

A. Let me go back. This may be one condition where it—no, there would be no contraindications to it, but there could be some cases where you might prefer D&E over medical complications.

I've seen one case in my whole life where we could not control the blood pressure. And so the—you know, the one-day thing would not have been as preferable as a quick surgical delivery. That happened after—after 20 weeks. I've never seen or heard or read about such a case occurring in the abortion range of weeks, but it could, and then you might want to do a [111] D&E.

Q. And have you seen any studies about the techniques that are used—abortion techniques for this condition?

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THE WITNESS: No, I don't think there are, because so few cases—like most of these conditions, so

few cases require pregnancy termination prior to fetal viability that I don't think you could—you could get such case reports.

Q. (BY MS. PARKER) Why is that? Do you need a certain number of cases in order to conduct a study?

A. Sure. Sure.

Q. And what is your view as to how many cases you need?

A. Depends on what you're trying to show. One case report is interesting. But, I mean, in America each year I don't think there are enough—you'd probably go ten years in the United States before there are enough pregnancy terminations for any one indication; that if you gather every single patient in there, you'd still be hard-pressed to come up with any statistically significant numbers.

Again, it is just rare as rare that [112] termination is necessary with the health of the mother. Granted, it can occur, but it's just incredibly rare.

Q. And so you don't have statistically a significant enough number of these cases to warrant doing the studies or have a study that would be efficacious?

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THE WITNESS: It would be difficult to randomize, for any given medical condition, any two procedures. It would be very easy, of course, to randomize elective terminations. Plenty of those are done. It could be done in a flash, randomizing D&X to D&E, if this were to be treated the same way as any other surgical procedure. But for medical indications, no, it would be very difficult to do that.

Q. (BY MS. PARKER) The same paragraph on page 5 of Exhibit 6 references severe HELLP syndrome.

A. Yes. That's simply a variant of severe pre-eclampsia.

Q. Do you know what characterizes it?

A. Low platelets, hemolysis, hepatocellular dysfunction.

Q. And what risks to pregnancy does it pose?

A. Death.

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Q. Okay. The next condition you indicate is a prior uterine incision.

[129]

A. Yes.

Q. And what do you mean by this?

A. Well, women who have had an incision in the upper part or fundus of the uterus.

Q. Would that have been for a prior cesarean section?

A. Or a fibroid removal. Potentially even a perforation at the time of a previous abortion.

Q. And what are the health risks that are posed in that situation?

A. Really—

MS. GOWAN: Objection.

THE WITNESS: —to the mother, none. But there is an increased risk in some of those situations of the uterus rupturing near term, which could—which, if appropriately handled, is not really going to be an issue for the mother, but could be devastating for the fetus.

But potentially a woman can terminate for any reason she feels like and she might have a fundal incision. And there is a situation where under some circumstances medical versus surgical could be—there could be a clear preference.

Q. (BY MS. PARKER) So, is there a preferred method of abortion where there's been a prior fundal [130] incision?

MS. GOWAN: Objection.

THE WITNESS: Well, of course, the first trimester, no. I mean, one could either use the early—the very early medical means for terminating an early first trimester pregnancy, one could use a suction D&C. But if you got into the late second trimester, if you're terminating beyond 20 weeks, let's say, I would say as a general principle, although there is no data to support this, it would be my opinion that a D&E would be preferable to a—to an induction.

Clearly, at term or in the third trimester, induction would be contraindicated. Once again, it's for fetal reasons. And so I don't have any data that the risk of rupture is actually greater in the 20-to-23-or-24-week range at all. But it would be my opinion that it probably would be. And that probably a D&E, if a woman so elected, would be a preferable means under those circumstances.

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Q. And you testified earlier that you've never done a KCL injection, is that correct?

A. For?

Q. Purposes of causing fetal demise.

MS. GOWAN: Objection.

THE WITNESS: Right.

Q. (BY MS. PARKER) And why not?

A. The only cases in which that has ever been desirable have been some women with what we call higher order multiples, quints, sextuplets, that sort of thing, which require multiple KCL injections. And because one is very concerned about not disrupting the two or three fetuses the woman has chosen to leave behind, we send those to people who do those all the time. And, fortunately, that's a rare circumstance.

In other words for safety—for safety's sake of the fetus—of the living fetuses—let me put it this way. KCL injection is trivial to the mother, it has no risks. But KCL injection or any injection of anything into a woman with sextuplets or quintuplets carries with it risks to the surviving twins, if one is doing selective termination.

And because those are triply rare, there's a [134] guy in Denver everyone sends their patients to from this area. So one person is really good at that.

Q. I think my question, though, was—

A. That's why I've never done it. We've sent them to Denver.

Q. That's the answer to the question. You've never done it because you send it elsewhere?

A. Correct, because of specific fetal risks.

Q. And you don't see any situation for doing a KCL injection, other than a situation where you have multiple fetuses and you're doing selective and some will survive and some won't?

MS. GOWAN: Objection.

THE WITNESS: Except a situation—right, I don't see any circumstances. But if somehow I've missed one in 20 years of critical care obstetrics and there was some situation under which D&X would be preferable to D&E, then KCL injection—which, again, is easy and to the mother a trivial procedure—could be done and this—and we have nothing to do with this law and the ban would not prohibit that from being done.

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Q. (BY MS. PARKER) To go back to an earlier question, you, yourself, do not do KCL injections; is that right?

A. That's right.

Q. And the reason you don't do them is that you don't have any circumstances where you find it necessary to do a KCL injection?

MS. GOWAN: Objection.

THE WITNESS: No. The only circumstances I've every [*sic*] encountered have been the high order multiples or the fetal—

Q. (BY MS. PARKER) And you refer those out?

A. I refer out. I've never encountered a situation where either medical induction or D&E didn't work in the abortion arena. But if it did, it would be easy enough to do. And again, hitting the fetal heart is much, much easier than hitting the umbilical cord with a needle, which we do all the time with relative ease. So it's not going to be a risk to the mother to do that.

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Q. (BY MS. PARKER) Are there any fetal anomalies that might necessitate termination of pregnancy?

MS. GOWAN: Objection.

THE WITNESS: Not for maternal health reasons.

Q. (BY MS. PARKER) But you're saying the fetal anomalies may—may be such that the mother would choose to terminate the pregnancy?

A. Yes.

Q. And I think you gave us some examples in your report. One was hydrocephaly?

A. Could be. That would be very rare. Anencephaly would be much more common.

Q. What is anencephaly?

A. The absence of development of the skull and cerebral hemispheres.

Q. And I take it in that circumstance termination is advisable because the fetus won't survive * * *.

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Q. (BY MS. PARKER) Is medical induction contra-indicated in certain circumstances where there are conjoined twins?

A. It depends upon the size of it and how they're conjoined and whether it's going to fit out.

But as I mentioned, D&X, to my knowledge, has never even been tried with conjoined twins. And the size of the head is the least of the problems in getting conjoined twins out. So I can't imagine D&X would be chosen under those circumstances.

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[148] * * * you don't see any basis for using D&X, because there are well-studied—there is a well-studied alternative in the form of D&E. Do you see that?

A. Yes.

Q. And you've mentioned several times during the course of the day a study of, I think, approximately 11,000 patients involving D&E; is that right?

A. Yes.

Q. What is that study?

A. Peterson, '83.

Q. That was published in 1983?

A. Yeah.

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[150] established, a physician could not do another alternative until there was, first, a study?

MS. GOWAN: Objection.

THE WITNESS: Once there is a—if you've got a condition and you've got a treatment or a procedure which is incredibly safe and incredibly effective with essentially negligible risk of long-term adverse outcomes, yeah. Then before a physician should embark upon a new procedure, especially one that poses, I think in the words of McMahon, significant and burdensome changes in the technique, it would behoove you to do this.

You treat this like any other new surgical procedure. You take it before IRB, have the study approved, conduct a prospective and randomized control trial and document what the true risks and benefits are.

Now, if you've got no alternative where all your procedures don't work at all, that's a different story. But you simply can't make that case. With the data available even 20 years ago on D&E that there wasn't an incredibly safe—as close to risk-free procedure as it comes for procedures, and before you differ from that, embark upon something new, yeah, that's the way we do it.

I mean, even to the point of sewing an [151] alteration in the way you sew a c-section scar, using one suture or two, requires prospective randomized trial. It was done in an appropriate fashion. Now, that's a trivial, minor, insignificant change in terms of risks, unlike this change of the D&E.

And I don't know why some people seem to think we give D&E a free ride just because it's politically correct when we don't give a free ride to other new diagnostic and therapeutic procedures until they've

been proven safe and effective. That's the incongruity of it all.

Q. (BY MS. PARKER) How do you prove something is safe and effective until you've had the study? How do you ever do the procedure to conduct the study until you've had the study?

A. You don't. But what you don't do is, first of all, make any claim that this new study that's never been studied—this new procedure that's never been studied is necessary to safeguard the health of the mother, which is absolute nonsense based on no data at all.

And then what you do if you think it might be sometime, then you can—you go through IRB, you construct a prospective, randomized trial, you carry it out with sufficient power—statistical power to give [152] you believable results, and then you publish it. What you don't do is just based on some anecdote or a group of anecdotal evidence say, This procedure is great, we don't really need to study it, when you've got this very safe alternative.

Q. Well, at the time that the D&E study was conducted by Peterson back in '83, were there no other methods of abortion that had been established as being safe?

MS. GOWAN: Objection.

THE WITNESS: Yeah, I don't think—there were significant—especially with the medical methods used at that time, significant complications and there were no really effective surgical alternatives other than hysterotomy, which carries with it huge morbidity, for the late trimester termination that was medically contraindicated.

Q. (BY MS. PARKER) What about prostaglandin injections? Weren't those in effect before the Peterson study came out?

A. Actually, you know, in '83, yeah, there were prostaglandins available. But, again, there was not a safe surgical alternative. It was recognized that there were indications—there were times—in fact, misoprostol was not used for that purpose at that point.

[153]

The principal agent was PGF2 alpha, and there was a recognition that was simply inappropriate for some patients.

So, now we're kind of in the wasteland where there is no acceptable surgical alternative. And people came up with D&E and then did, in fact, publish large series showing its safety and efficacy as much they could. But now we've got one.

And, you know, I mean, the incredible thing is that this argument has been going on—I mean, the—I would say abortion advocates have been touting the wonders of D&E and how it's incredibly safe and has no significant risks and it's just great. And then suddenly those very same people are telling us, Oh, my gosh, D&E, we've got to come up with a new procedure.

Unfortunately, the data published by the large abortion clinics does not bear out any allegations that D&E is anything other than incredibly safe and an incredibly effective procedure. So if we're going to alter it, let's do science and not do ancedotes.

Q. You indicate on page 8 of your report that, fewer passes with an instrument is only an issue if trauma is done with a pass.

A. Yes.

Q. Do you see that?

* * * * *

[155] you're referencing?

A. That was the French name. Jacot, was it? Jacot, '93, comparison of suction D&C with D&E. And again, the difference wasn't statistically significant. But in an absolute sense, there was actually less perforations with the D&E procedure than with the D&C procedure.

So, in fact, there is some data. Not only don't I agree with that theoretically, that the more passes you do the greater chance of perf, but what limited data there is suggests it's not true. And if it were, would it justify the extra dilatation with unknown effects on future reproduction? Not without study.

Q. Is it—do you know whether cervical laceration is a known complication of D&E?

* * * * *

THE WITNESS: I'm sure it is. The more you dilate, the more you lacerate the cervix, sure. Sure, the more you may lacerate the cervix.

* * * * *

[158]

* * * * *

Q. (BY MS. PARKER) Right. You indicated you don't know how much dilation of the cervix is used with a D&X.

A. No, we know. 75 percent of the biparietal diameter. I'm not claiming that one can realistically compare directly that degree of dilatation with the old accouche-

ment force where you might dilate the cervix to ten centimeters mechanically, I'm simply saying that we know that excessive dilatation causes all sorts of problems.

Q. But—

A. Why subject a woman to dilatation followed by more dilatation without any evidence that actually that doesn't cause subsequent reproductive problems?

[159]

Irresponsible.

* * * * * *

[161]

* * * * *

Q. How much dilatation can you go up to, to be safe?

A. Nobody knows, nobody knows. But except that you can go up to the amount that you can do for a D&E and be safe.

Q. And what is that amount?

A. Well, enough to pass the forceps—enough to pass the Sopher forceps and extract the fetus, because we have huge volumes of data showing you can do that amount of dilatation and do it safely. We simply don't know. Maybe it will turn out that, in fact, you can do a D&X and you don't cause subsequent reproductive problems. Could be, maybe it won't be. But in the absence of data and with a perfectly good alternative, what responsible person is going to recommend that—

[162]

Q. So your—

A. —to their patients?

* * * * *

It's your position that there is no current data, such as we know, whether D&X is safe or not safe; is that correct?

MS. GOWAN: Objection.

THE WITNESS: Yes, that is.

* * * * *

[174]

Q. There are risks of cesarean?

A. Of course there are.

Q. And what about as compared to the decompression?

A. Well, the risks to the mother of decompression are essentially zero in good hands.

Q. And are there any quantifiable risks to a cesarean section?

A. Of course there are.

Q. What are those?

A. Infection, hemorrhage, injuring other organs.

Q. Your report also states that there are times when examination of the intact fetus after birth may help in a diagnosis of a fetal anomaly. Is that your opinion?

* * * * *

THE WITNESS: A fetal syndrome, yes.

Q. (BY MS. PARKER) And what is your opinion as to the best method that should be used to achieve intactness?

* * * * *

THE WITNESS: In the majority of cases, it's not necessary, because you made the diagnosis by ultrasound or by amniocentesis. But there certainly are other cases in which examination of the intact baby [175] might help you put a name on the syndrome, if you're interested in putting a name on that syndrome.

And under those circumstances, the most appropriate ways would be medical induction of labor.

Well, the choices would be medical induction, killing the fetus by one of the methods we mentioned, and then doing a D&X.

Q. (BY MS. PARKER) KCL or the cord compression?

A. Or the Digoxin. And then doing a D&X.

Actually, the preferred method would be medical in all cases, because then you don't destroy the brain. And the brain is heavily involved in many serious genetic syndromes and examination of the brain may be beneficial. So by far and away, the method of choice would be simply medical termination.

The second medical choice would be simply to—you could—would be either a plain old D&X—and I do mean D&X—or to kill the baby first and then do a D&X. Both of those would be equally good medically—equally appropriate, equally safe medically. Both of them would be inferior to medical induction, in most cases.

Q. What about those circumstances where you testified earlier where medical inductions are contraindicated?

* * * * *

[176]

A. Yeah, then you're right, some small percentage of women where medical induction is contraindicated—a small percentage of those women will have anomalies, and a small percentage of those anomalies would be severe enough to warrant termination. And a small percentage of those women would choose termination. And a small percentage of those women will need the intact fetus to put a name on it. And a small percentage of those women will need an intact fetus but don't need the brain to put a name on it.

And under all of those—when such a woman is found someday that, in fact, medical termination will not be the appropriate thing for her but, in fact, either D&X or first killing the baby and then performing a D&X would be equally safe and effective methods.

* * * * *

[178]

* * * * *

Q. And other than the declarations of the plaintiffs' experts in this case, have you encountered any other facts or articles or other matters that are not consistent with the opinions you've expressed—

MS. GOWAN: Objection to the form of the question.

Q. (BY MS. PARKER)—in our case?

A. Sure.

Q. And what were those?

A. Well, even in the—there was something, I believe, even in this—in the law or somewhere that * * *.

* * * * *

[179] said partial-birth abortion increases the risk of amniotic fluid embolism. Well, 14(A), much of that I disagree with.

Q. What does 14(A) says?

A. 14(A) talks about the risks of partial-birth abortion to women who undergo this procedure.

Q. And you say you disagree with most of that?

A. Yeah. Well, I disagree that those are—that any one could say those are risks. Theoretically, they could be, but I wouldn't be in a position to say that those—the partial-birth abortion increases those risks compared to D&E or any other method of termination anymore than anybody could say that partial-birth abortion does not increase those risks and in any way improves the health of the mother.

* * * * *

[183] spontaneously. They evolve by an idea being subjected to prospective, randomized trials, the safety of a new procedure and the benefits being demonstrated, and then that procedure being adopted for general use.

Q. (BY MS. PARKER) So is it your view that there is no procedure—that no procedure should be done or

followed unless there has been a prospective, randomized trial proving its safety and efficacy?

* * * * *

THE WITNESS: No, that's not my opinion. As I mentioned before, if you have a—if you've got a problem that has no good answer, and there is no procedure, in fact, that's ever been shown to be safe and effective and almost everybody dies as an example, then it's fair game for just about anything, okay?

But when there is a—for better or for worse, when on February 12th there is a well-established, incredibly well-studied procedure, which is shown to be incredibly safe and incredibly effective for dealing with a specific problem under those circumstances, yes, before one engages in a significant and burdensome—to use the words of one of the greatest proponents of partial-birth abortion—significant and burdensome change in technique, one absolutely does need to have prospective, randomized [184] trials demonstrating safety, especially when there are at least good theoretical reasons to believe it might not be as safe, and that's the increased cervical trauma.

Q. (BY MS. PARKER) And do you believe that procedures that a physician performs that have not been subjected to prospective, randomized trials and where there are other safe methods should be criminalized?

* * * * *

THE WITNESS: That would be too broad. No, but it would be generally bad practice. Now, again, where there are established procedures that essentially always work with negligible risks, a doctor who

launches out on his own—obviously, if you're in your office, you can do anything you want.

But a doctor who launches out on his own on a new procedure, unless for some reason this doctor is given carte blanche for political consideration, in fact, that doctor would, under all circumstances, be subjected to significant censure and discipline. It's just basic patient rights. You don't experiment with something new unless it's been done appropriately and set up appropriately.

Q. (BY MS. PARKER) Have you ever used an unstudied or an experimental procedure in your career?

* * * * *

[190]

Q. When have you done that?

A. All the time. I do it every day with preterm labor. Okay. You picked the wrong example because, in fact, terbutaline did have some initial apparently good science behind it. But, you see, this is the difference. There is no proven effective method for stopping preterm labor. Nothing seems to work and it's a terrible disease.

So when you have got a terrible disease and you don't have any method that seems to work, then it's perfectly justified to hunt around for a method. But if there were a method that worked essentially all the time and showed the complications rate associated with D&E of serious complications, no one in their right mind would vary from that one iota in the treatment of preterm labor, with that safety and efficacy record, without first clearing it through an IRB and going

through the appropriately conducted prospective trials. That's the difference.

Q. So what do you use for preterm labor that hasn't been subjected to randomized, prospective trials?

A. Well, actually, most of these drugs have been, but not as well as I would like them to be. So Indomethacin, Methedopine. Even Magnesium Sulfate hasn't been studied as well as it could have been. Put * * *.

* * * * *

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No. 05-1382

In the Supreme Court of the United States

ALBERTO R. GONZALES, ATTORNEY GENERAL,
PETITIONER

v.

PLANNED PARENTHOOD FEDERATION OF AMERICA,
INC., ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

JOINT APPENDIX
(VOLUME 5)

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UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

No. 03-08695

NATIONAL ABORTION FEDERATION, MARK I. EVANS, M.D., CAROLYN WESTHOFF, M.D., M. SC., CASSING HAMMOND, M.D., MARC HELLER, M.D., TIMOTHY R.B. JOHNSON, M.D., STEPHEN CHASEN, M.D., GERSON WEISS, M.D., ON BEHALF OF THEMSELVES AND THEIR PATIENTS, PLAINTIFFS

v.

JOHN ASHCROFT, IN HIS CAPACITY AS ATTORNEY GENERAL OF THE UNITED STATES, ALONG WITH HIS OFFICERS, AGENTS, SERVANTS, EMPLOYEES, AND SUCCESSORS, IN OFFICE, DEFENDANT

DEPOSITION OF
MARILYNN CONNERS FREDERIKSEN, M.D.
Feb. 17, 2004

PRESENT:

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1-312-201-9740
By:
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Appeared on behalf of the Plaintiffs

PRESENT (Continued):

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By:
MS. DEBORAH ADLER
Appeared on behalf of Planned Parenthood Federation of America

* * * * *

[5]

Q. What is your medical specialty?

A. Obstetrics and gynecology.

Q. Do you have a subspecialty?

A. Maternal-fetal medicine and clinical pharmacology.

Q. Pharmacology, you said?

A. Clinical pharmacology.

Q. Any other specialty?

A. No.

Q. Subspecialty, I should say. Do you perform pregnancy terminations?

A. Yes, I do.

[6]

Q. Under what circumstances?

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. I do terminations until approximately 23 5/7 weeks gestation. Anything beyond approximately 17 weeks will have been for either fetal or maternal indications.

* * * * *

[7]

* * * * *

Q. Can you estimate how many pregnancy terminations you have performed in the course of your career?

A. I have done hundreds. I don't know exactly how many I have done.

* * * * *

[16]

* * * * *

Q. When you are doing a D&E in the second trimester, what do you tell the patient about what you plan to do, and if it varies by gestational age, you can tell me that, as well?

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. What we plan to do is to pretreat the [17] cervix with Laminaria. Laminaria are seaweed twigs which absorb water from the woman's body and swell, thereby causing gradual dilatation of the cervix.

This reduces the risk of uterine perforation. It allows a patient to have adequate dilatation of the cervix to undergo a second trimester abortion with decreased complications.

Depending upon gestational age, the cervix will be prepared either by one, two, three, or more sets of either Laminaria and/or misoprostol.

Up until around 16 weeks, one episode of placing Laminaria in the cervix is all that is necessary to achieve enough dilatation to allow for extraction of the fetus and the products of conception so that there won't be injury to the mother's tissues or uterus.

After 16 weeks and before—between 16 and about 18 weeks, we use two sets of Laminaria.

These can be as close as three to four hours and as long as 12 hours or more between applications of the Laminaria.

After—at 20 to 23 weeks, we use three to four sets of Laminaria so that we achieve a very [18] widely dilated cervix so that the majority of fetal parts can come out hopefully intact because it assures that less instruments are going into the uterus and, therefore, it is a safer procedure for the mother.

That requires the patient to be in the office several times during the day or sometimes one day and then the morning of the following day, and I have used smaller low dose misoprostol as a mechanism by which the cervix can also be softened and dilated, and it helps

with the Laminaria as well as the amount of dilatation that I can achieve within this period of time.

* * * * *

[25]

* * * * *

Q. How many D&Es would you say you have performed over the course of your career, second trimester?

A. Hundreds.

Q. Have you also performed induction abortions in the second trimester?

A. Yes, I have.

Q. And how many would you say you have done in the course of your career?

A. Hundreds.

Q. At what gestational ages have you performed induction abortions?

A Generally speaking, the induction abortions are usually over 20 weeks. I have performed them to 24 weeks or just prior to 24 weeks, and then I have done lethal anomalies beyond 24 weeks.

* * * * *

[27]

* * * * *

Q. Your understanding is that the purpose of getting the fetus out as intact as possible is in order to do a pathological examination of the fetus?

A. That is the reason—it is one of the reasons. I can give you other reasons.

Another reason would be because with an intact procedure, while getting the fetus out as intact as possible, there is less trauma to the uterine cervix and less chance for traumatic lacerations of the uterine cervix. It is also an easier procedure because you put the forceps in [28] fewer times, and the fetus is extracted with fewer—less instrumentation of the uterus than with a strict dilatation and evacuation.

* * * * *

[WOLSTEIN EXAMINES FREDERIKSEN]

[29] is to try to get the fetus out as intact as possible. This may or may not be possible because of how much cervical dilatation that has been achieved preoperatively.

It also can be dictated by the fetal lie at the particular time of the procedure. Breech presentations are easier to grasp the feet and deliver not only the foot, but with careful manipulation of the fetus, you can deliver the fetus to the trunk where you can essentially do a breech delivery where you are left with a fetal head that can either be compressed or the contents of the fetal head can be reduced by using a scissors to enter the skull and then cause the disruption of the fetal brain. Afterwards, the remainder of the fetus can be then delivered as intact as possible.

* * * * *

[34]

* * * * *

Q. When you have performed the intact D&X, where have you done it?

A. Northwestern Memorial Hospital.

Q. Have you done it anywhere else?

A. I only operate at Northwestern Memorial Hospital.

* * * * *

[48]

* * * * *

Q. So, occasionally, when you use the term "D&E" you are referring to intact dilatation and extraction?

MS. CHAITEN: Object to the form.

BY MS. WOLSTEIN:

Q. I am just trying to understand—

A. Can I explain myself, please.

[49]

Q. Of course.

A. Because an intact dilatation and extraction, in ACOG's definition, includes things that are not necessarily always done with D&E and we can get an intact fetus delivered. And many of these procedures are variations on established obstetrical procedures that are used for the delivery of the breech infant. What this is, is essentially a breech extraction. They include conversion from a vertex to a breech in this definition.

Not all fetuses present as vertex in the midtrimester, nor is the intact D&X always necessary to convert to a breech. In fact, sometimes you can compress the head and then the whole fetus can be delivered as a vertex intact, virtually intact, so you are not doing these four steps.

By ACOG they basically say, "If you don't do these four steps, you have not done a D&X," and that is

where we get involved in what actually are we talking about because, in reality, we are doing D&Es and varying what we are doing with them to essentially do intact deliveries of [50] the fetus so that we can do prenatal diagnosis or we can make sure that the fetus has been delivered so that we don't have to multiply explore the woman's uterus to get remaining fetal parts and we won't necessarily do all of what they say.

Now, they basically make the stipulation that if you don't do this, you don't do a D&X. So then what do you do? I am not quite sure because if you actually compress the head and you got the whole body out, delivered when you delivered—compress the head as a vertex, delivered the whole fetus intact, and I have done it. What have I done? I don't know. But my intent was to evacuate the uterus, and I have succeeded in doing that. So, by definition, I have done a dilatation and evacuation.

* * * * *

[83]

* * * * *

Q. So in the period 16 to 20 weeks, you would not do an induction to terminate a pregnancy at that age, would you, you personally?

A. I have done them and it is possible to do them. If you compare risks and complications with an induction versus a dilatation and evacuation, at our hospital, we have a four times higher rate of complications with induction than D&Es.

Q. At what age are you referring to?

A. We did a study looking at complications after second trimester termination between—I don't know if

we defined it as 13 weeks until 23 weeks. I don't remember exactly the definition.

[84]

But, basically, what we looked at and the hypothesis that we posited was that we did not think that there was an increased risk of uterine—of complications related to cesarean section at our hospital.

There was a paper done out of the University of Alabama that showed that there was a high rate—I don't remember exactly what they came up with, but I think it was a factor of four times higher risk of needing postpartum transfusion and uterine rupture for patients who had a prior cesarean section. So we looked at our statistics.

The difference between Alabama and Northwestern were that the majority of our patients were D&Es and all of the patients at Alabama were inductions, and we showed that there was not any higher risk to cesarean section and the difference was related to the fact that we did D&Es and not inductions. D&Es being safer for the mother than induction.

Q. So D&E is safer than induction at what gestational ages?

A. In the mid-trimester, if you are terminating the pregnancy, it is safer across the [85] continuum of 13 to 23 weeks. 23 1/2, 24 weeks.

Q. What is that based on?

A. Our study from Northwestern.

Q. And the University of Alabama paper?

A. And also, as a comparison paper, that we had approximately the same number of cases and we just did not have the complications that they had had.

Q. And is your view based on anything else other than what you have just mentioned?

A. Well, that is only one piece of it. There is a body of evidence that says that D&Es have a lower complication rate than inductions, and that goes back some 20 years over a long period of time comparing different modalities of second trimester terminations.

Q. And are you referring to at any particular gestational age when you are referring to the body of evidence showing D&Es with a lower complication rate than induction?

A. The majority of the information is through approximately 19 weeks. We have not had a lot of objective data looking at induction versus D&Es between 19 and 23 weeks, and there are several [86] papers out there that basically do a disclaimer that because of lack of numbers, they really can't make an adequate comparison.

Our paper is certainly not perfect and we have some flaws in what we came up with, as well, that limits what we can say about it, but we did have a much—we didn't have a higher risk of uterine perforation or complications after cesarean section with D&Es, where they did. And, number two, we had a lower overall complication rate, and that is indirect evidence that D&E through 23 plus weeks is safer than induction.

* * * * *

[97]

* * * * *

Q. And when you—and in talking just now about D&E versus induction at 13 to 23 weeks, are you including in that—in your definition or in your reference to D&E, intact D&X, as referred to [98] in the ACOG paper?

A. It would be hard to differentiate a D&E from a D&X on the basis of the statistics that are compiled on a yearly basis by the CDC and as well as the Guttmacher Institute because I do not think that either agency classifies D&X as to the procedures. I don't know, but I think that is the case.

And over a long period of time, the statistics on D&E have been shown to be safer. I have included that from the CDC statistics in my medical student lecture, and so I don't think that D&X really falls in that bailiwick, but I can't tell you that none of the D&Es might have been a D&X.

* * * * *

[107]

* * * * *

Q. Is there any added risk to the mother in doing an intracardiac KCl injection in conjunction with your induction procedures?

A. In certain circumstances, yes, it is.

Q. In what circumstances?

A. If you are dealing with a patient who has an intrauterine infection. You are putting her at increased risk. If you are dealing with a very obese patient, you may not be able to do it.

You—it is an additional risk. It is a needle going into the uterus and, as such, even with very careful ultrasound guidance, you may not achieve it. You may not be able to do it, especially if [108] you have low amniotic fluid volumes.

Q. What is the increased risk or likelihood of infection in doing a KCl injection? Can you assign a number?

A. Well, I can't because I really don't have any way to assign a number. It is a transabdominal technique, and you are going into the uterus. Now, if there is infection in the uterus, then you have the likelihood of seeding the abdominal cavity as well as the subcutaneous area of the mother. Likewise, you also have the ability to pick up bugs from surfaces of the skin, even though you have cleansed the skin prior to doing the procedure and putting bacteria into the uterus.

So, yes, it is an additional risk. I can't give you exactly how much risk. If you think about it analogous to an amniocentesis, infection with amniocentesis happens in about 1 in 1,000 procedures, so that is the only number I can come up with.

Q. How about with an obese patient, is there an increased risk?

A. An obese patient, you have a problem of actually reaching the fetus. You also have a [109] problem of visualizing what you are doing. The adiposity decreases your ability to visualize. It also limits what you actually can do, so it makes it a very technically difficult procedure, one that the patient won't necessarily tolerate well, and it is just—it is an added burden on the patient to do that kind of procedure.

* * * * *

[115]

* * * * *

Q. If you have a patient and an induction abortion is started and sepsis ensues, what would you do to complete the termination or what could you do?

A. It really would depend upon the amount of cervical dilatation. Often in those cases you have enough cervical dilatation that you can go in and empty the uterus as a D&E or a D&X, and sometimes the patient has been laboring alone and you actually can get the fetuses out intact.

Q. Continuing the induction or using one of the D&E or D&X?

A. D&X. Because what happens when you have—the real problem with sepsis is, is not only getting the fetus delivered but getting the placenta out. And you can ensure that you can [116] empty that uterus and empty that placenta by doing a D&E in that situation, rather than waiting around with a placenta in place, waiting around with an unstable patient.

It is a very, very bad situation, and we have had two patients in the last year that have fallen into that category, one of which we delivered triplets as intact.

* * * * *

[161]

* * * * *

Q. Acute fatty liver of pregnancy, is termination medically indicated in the second trimester in that scenario?

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. Yes.

BY MS. WOLSTEIN:

Q. Is a particular method indicated?

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. It would be safer to do a D&E than it would be to do an induction. Again, we are talking in generalities here.

BY MS. WOLSTEIN:

Q. Why would it be safer to do a D&E?

A. Because you get the procedure over under a defined period of time rather than over a prolonged period where you have to medically manage the patient, as well. Prior to getting the [162] placenta delivered, you are increasing her risks of complications, the longer you keep her pregnant. A similar scenario would be for severe preeclampsia.

Q. In your view, it would be better to do a D&E than an induction?

A. It is always better to do a D&E than an induction.

Q. And in the case of severe preeclampsia, is— either as between a dismemberment D&E and a D&X, is one or the other contraindicated for severe preeclampsia?

MS. CHAITEN: I object to the form.

BY THE WITNESS:

A. No. But you have to remember it is a continuum. When you start a D&E, you can actually be doing a D&X.

BY MS. WOLSTEIN:

Q. With acute fatty liver of pregnancy, is a dismemberment—is either a dismemberment D&E or a D&X superior in that—with that condition?

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. Actually, an intact D&E would be preferable in this situation because there would be [163] less bony spicules exposed to the cervix and cause cervical lacerations.

BY MS. WOLSTEIN:

Q. And does that relate specifically to something about acute fatty liver of pregnancy, or is that based on your view that it is better to do a D&X because you get fewer bony fragments?

A. Any time you have an increased risk of hemorrhage and a disseminated intravascular coagulation. An acute fatty liver of pregnancy, you can have disseminated intravascular coagulation, so, therefore, you have increased risks of hemorrhage. Therefore, you decrease your risk to the mother if you deliver it as intact as possible.

Q. Does use of instruments in someone who is at risk of hemorrhage pose any added risk to the mother?

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. It depends upon what instruments you are talking about. Certainly, if you are talking about a D&E, the more times I have to put my instrument within the uterus to get the fetal parts out, the [164] higher the risk of perforation. That having been said, the more widely dilated the cervix is, the less likelihood I am going to have any problem in delivering the fetus as intact as possible.

BY MS. WOLSTEIN:

Q. Is dismemberment D&E contraindicated in the case of acute fatty liver of pregnancy?

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. I think that there is no body of evidence to say that it is contraindicated. It is—it is a preference on the part of the surgeon, and there may be medical conditions such as I have alluded to, including disseminated intravascular coagulation, which can be associated with acute fatty liver of pregnancy which would say that the dismemberment increases the risk to the mother and, therefore, a D&X is preferable.

Q. How about placental hemorrhage, is pregnancy termination medically indicated in those cases?

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. Placental hemorrhage can be a cause of [165] maternal death. Pregnancy termination is indicated. If you induce a patient with placental hemorrhage or abruption or a chronic abruption, you actually increase

the amount of blood that she can lose during the process of the induction.

So although D&Es are not available in 50 states in the United States, it would be preferable if she had a D&E or a D&X because, actually, if you can get ahold of the fetus, you can use that to tamponade your placental abruption or chronic abruption and deliver the fetus as intact as possible, thereby getting the placenta delivered quickly so thereby you decrease her total blood loss.

Q. And, in your view, is induction contraindicated in a woman with placental hemorrhage?

A. I think so. That is my opinion.

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[171]

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Q. * * * And I think—how about pulmonary hypertension, would that be a condition for which pregnancy termination is indicated?

A. Yes.

Q. Is any particular method—if the woman is in the second trimester, is any particular method indicated?

MS. CHAITEN: Object to form.

BY THE WITNESS:

A. Actually, a D&E would be preferable because labor is not in her best interest. I have another one. Paroxysmal nocturnal hemoglobinuria where prostaglandins are contraindicated.

BY MS. WOLSTEIN:

Q. So you would want to do a D&E in that scenario?

A. Yes.

Q. Or a D&X?

A. Either one.

[172]

MS. CHAITEN: Object to the form.

BY MS. WOLSTEIN:

Q. Would one or the other be preferable based on the mother's condition?

MS. CHAITEN: Objection to form.

BY THE WITNESS:

A. A D&X would be preferable because you have no platelets, as well. You have low hemoglobin.

BY MS. WOLSTEIN:

Q. Because—preferable because it is lower risk of perforation from instruments?

A. Lower risk of blood loss.

Q. So, in your view, D&X poses a lower risk of blood loss than a dismemberment D&E?

A. Yes.

Q. And what is that view based on?

A. It is based on my experience and the fact that bony parts can lacerate the cervix as they are brought through the cervix, and the cervix is one—is something that you can actually nick the branch of the uterine artery at the internal os of the cervix and cause enough bleeding that you have to either do a hypogastric artery ligation or [173] else a uterine artery embolization to stop bleeding.

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[176]

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Q. If you can turn to your expert report, 40-C.

A. What page are you on, please?

Q. I am on—I'm going to ask about page 2.

Well, is it your opinion that a D&X is safer for the mother in a dismemberment D&E at some point in gestation?

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. Yes.

BY MS. WOLSTEIN:

Q. And what point would that be?

[177]

A. It is throughout the second trimester.

Certainly beyond 17, 18 weeks it is definitely safer.

Q. What is your view that it is safer based on?

A. My experience.

Q. Anything else?

A. No.

Q. What makes, in your view, the D&X safer in D —than dismemberment D&E at 17, 18 weeks and beyond?

A. Dismemberment requires the forceps to go into the uterus multiple times. Whereas, when you are doing an intact D&X, you can get the fetus out as intact as possible. It is safer because there is less instrumentation of the uterus.

Number two, there are less bony parts, and there are bony parts before—beyond 20 weeks and you will get them and they can be very difficult to get them through the cervix without lacerating the cervix.

Another thing is that if you have—you have more ability to—if you get ahold of the fetus and can bring it through the cervix virtually [178] intact, it is a shorter procedure and you can get your placenta out faster and you can end the procedure faster.

Q. Your report also mentioned advantages for testing to ascertain the cause of fetal anomalies as an advantage of D&X?

MS. CHAITEN: Could you show us where you are?

MS. WOLSTEIN: Yes.

BY MS. WOLSTEIN:

Q. I will read the sentence. It is the second to the last sentence, "Finally, an intact fetus offers advantages for testing to ascertain the cause of fetal anomalies, an advantage particularly important in a practice such as mine involving high-risk and very much wanted pregnancies."

A. Fetal anomalies range from Down's, which any lay person is probably familiar with, to body stock anomalies where the fetus is stuck to the placenta and induction is really truly contraindicated.

If you can get the fetus out intact as possible, you can confirm ultrasound findings. We have progressed from the diagnosis of neural tube [179] defects and chromosomal anomalies to being able to pick up subtle changes or subtle differences in dysmorphic

features, not necessarily facial features but that we see in the hands and the feet.

Case in point, I had a patient who was terminating a fetus for bilateral club feet, and the hands, when I got them out intact, showed a fixed contracture, as well. So we were not dealing with just club feet. We were dealing with an arthrogryposis probably on a neuromuscular basis.

Getting the fetus out as intact as possible provides a perinatal pathologist with the best opportunities to help us pin down the anomaly and then help us to counsel the patient about recurrence risk as well as provide a plan of management for prenatal diagnosis, either with the gene, if we have it, or early ultrasound if we have to rely on ultrasound.

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[197]

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Q. Tell me if you agree or disagree with the following statement: "D&X is safer than dismemberment D&E because it reduces the risk of [198] bony fragments lacerating the uterus"?

A. I agree with that.

Q. So you can say with certainty that it is—that D&X is safer than D&E, in that it reduces the risk of bony fragments lacerating the cervix?

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. Well, in my hands and my experience, getting the fetus out as intact as possible ensures that there are

less bony fragments that may lacerate the cervix, thereby reducing the risk of cervical laceration.

BY MS. WOLSTEIN:

Q. You also mentioned instrumentation, that D&X involves fewer passes of instruments in and out as one reason you consider it safer than dismemberment D&E?

A. Yes.

Q. What is the basis of that view?

A. Experience.

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[202]

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Q. Do forceps pose a risk of laceration to the cervix?

A. In my opinion, they don't.

Q. Does use of a scissors, in a D&X or a D&E, as you have described how you use the scissors, does that pose a risk to the mother?

A. The way I use it, no.

Q. Do you consider a scissors that you use in a D&E or D&X potentially more dangerous to the mother than a forceps, if a mistake is made?

MS. CHAITEN: Object to the form.

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[203]

A. A scissors might be more dangerous, yes.

BY MS. WOLSTEIN:

Q. How so?

A. Because it is a sharper instrument.

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[217]

Q. * * * Is it your view that the literature supports the view that intact—the intact variant of D&E or D&X or intact D&X is safer than induction?

A. There are no statistics comparing that, but doing an intact D&E as a variant of D&E—and the CDC does not separate the two procedures, so it is going to be melded into a D&E, which comprises 99 percent of abortions within the United States right now and that has the lowest complication rate for second trimester terminations for women.

Q. And you are referring to what is referred to in that literature as D&E?

A. The D&E will include the D&Xs on a large population basis, which is, by law, keeping track of abortion mortality and morbidity statistics nationwide. And that is the CDC statistics, and they don't make a distinction.

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UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

No. 03 Civ. 8695

NATIONAL ABORTION FEDERATION, PLAINTIFFS

v.

JOHN ASHCROFT, IN HIS CAPACITY AS
ATTORNEY GENERAL OF THE UNITED STATES,
DEFENDANT

DEPOSITION OF AMOS GRUNEBAUM, M.D.

Feb. 2, 2004

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Q. Can you please briefly describe for me your duties as the director of clinical maternal fetal medicine at New York Cornell?

A. My duties include the clinical care for high risk pregnant woman, the teaching of residents and of medical students, and I also have a session in the faculty practice offices at Cornell where I see women in ObGyn, both pregnant and non-pregnant.

I also give lectures and attend conferences, and I perform medical and surgical procedures in the operating rooms at Cornell. I make rounds on patients.

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[47]

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Q. Why don't you read the first sentence out loud of paragraph 9, Doctor.

A. I've participated in and performed approximately 100 D&Es, including intact D&Es over the past three years.

Q. How many of those 100 D&Es were not intact D&Es?

A. About 50 percent, 60 percent, about 50 percent to two-thirds.

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[61]

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Q. I'm sorry. I don't understand that.

[62]

What do you mean the original diagnosis?

A. If they come with a diagnosis of abnormal fetus or chromosomal abnormality, they are able, instead of me just saying, okay, you want it done; let's do it. I can also counsel them at the same time about that issue.

Many of my patients ask me how sure can you be that this was the right diagnosis because that's really important for them. They're also going to ask me, can I hold the baby after I deliver after the procedure. And some of my patients ask me can you try to deliver it intact so I can hold the baby and see the baby. I know that there are malformations. I would like to just reassure myself that I did the procedure for the right reason.

Q. What do you tell them if they ask you that?

A. I tell them I cannot deliver that I can deliver the baby, the fetus, completely, but I will make a safe attempt to do so. And some of them say that they have made arrangements for pathologists to examine the fetus. And if it's done completely, that will help the pathologist to examine the fetus.

I have experienced that patients who are able to hold the fetus after I tell them about [63] this, sometimes they feel better about this and are more likely on a personal bases to accept the procedure.

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[66]

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Is there a difference in your mind in terms of the amount of cervical preparation you perform for those two?

A. I believe I've testified that I don't prepare a patient differently for an intact D&E as compared to the D&E, per se. I prepare all patients for a D&E procedure, and one form of it could be an intact D&E.

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[108]

[GOWAN EXAMINES GRUNEBAUM]

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Q. And at what gestational age is the tissue of a—does the tissue permit the intact extraction, as you described it?

A. It permits it throughout pregnancy, but it's easier after 20 weeks because the fetus is bigger. Before 20 weeks it's less likely to be successful because as you pull on the fetus you are more likely to dismember it.

Q. And that's because of the nature of the tissue?

A. And because it's also smaller, much more fragile.

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[138]

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Q. Let's focus on the operative time which I think you delineate more specifically in paragraph 12 of your report. What's the basis of your statement that intact D&E takes significantly less time than D&E by dismemberment?

A. It's the observation of cases I've seen and cases I've done.

Q. And what have you noticed?

A. I've noticed that if you can do a D&E safely as an intact D&E, the procedure to deliver the fetus is faster than it is with a dismemberment D&E.

Q. How much faster?

A. Significantly faster.

Q. What does that mean?

A. Maybe twice as fast, half as fast.

Q. Give me some minutes, some time. 10 minutes? 20 minutes?

A. Difficult to say. I can't pinpoint it [139] down because if it's difficult to do it with intact D&E, then it will be more difficult to do when it's normal D&E.

Q. What do you mean it's difficult to do?

A. Because the fetus may be too high or you may have difficulty getting the fetus, but I would say in general it's probably twice as fast.

Q. Are you saying that sometimes it might take longer to do the intact D&E because of difficulties you might have with getting the fetus than it would to do the D&E by dismemberment?

A. No, I'm not saying that. I'm saying some intact D&Es take longer or shorter than others.

Q. But your view is they're always faster than D&E by dismemberment?

A. No. They're usually faster.

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[145]

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Q. I would like to focus for a minute on your statement in paragraph 12 that the intact D&E decreases the amount of anesthesia that the woman is exposed to as opposed to D&E by dismemberment. What's the basis for that statement?

A. It's the same as the first sentence. If it decreases the operative time, then it decreases the amount of anesthesia because the woman gets less anesthesia.

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[147]

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Q. What are you referring to in particular?

A. When you use instruments and you enter with the instruments into the uterus, you can injure the uterus and that can lead to blood loss. With the intact D&E your risk of using those instruments and injuring the uterus is significantly less and thus decreases the blood loss.

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[150]

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Q. Paragraph 13, what's the basis for your statement that, quote, intact D&E decreases the risk of injury to the cervex and the body of the uterus, which is one of the known complications of D&E, closed quote?

A. With a dismemberment D&E, we usually use instruments which we push blindly into the [151] uterus, so there is a risk that we can perforate the uterus with those instruments. It's an extremely scary situation, and I don't think any doctor will tell you differently who has done this procedure that it is associated with a potentially complicated outcome.

With an intact D&E, you do not have to take those instruments and blindly put them into the distended uterus and remove fetal parts. So with the dismemberment, the risk is higher. In fact, you do an intact D&E, and the placenta comes spontaneously. The risk of perforating the uterus is as close to zero as you can be because there is no instrument that enters the uterus.

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[159]

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Q. In paragraph 15 of your report you state that having intact D&E available is particularly important for women with certain conditions. Then you say, quote, these include, for example, women with an increased risk of hemorrhage or infection, period, closed quote. What are you referring to there specifically?

A. Women who have blood disorders, for example, who are more likely to bleed. For them the intact D&E is less life-threatening if you can deliver the fetus intact because the risk of injury to the uterus is lessened. And if you do have injury to the uterus in a patient who has a risk of hemorrhage she can bleed to death.

Q. Wouldn't you—well, I should say why if a woman had a blood disorder would you even want to do a D&E procedure at all? Why wouldn't you want to do termination by prostaglandin induction?

A. Because it's the woman's choice and it's her option, and you can offer her. With a [160] prostaglandin induction, as we discussed before, sometimes you're not successful. Sometimes the cervex doesn't open up. It's a long procedure. Some women feel that they do not want to be in the hospital for days at a time.

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Q. You wouldn't suggest that that might be preferable over a D&E procedure or intact D&E procedure where there are some instruments used?

A. If you've ever seen a D&E done by an experienced person, you would never suggest a prostaglandin induction to a woman to stay in the hospital for that long time and to undergo hours and hours of labor.

Q. No matter what the blood disorder?

A. Most experienced doctors with D&E feel very confident to do it in those cases.

Q. Do you put yourself in that group?

A. Soon not anymore because I don't do them anymore.

[161]

Q. Why did you stop?

A. Because of the law, because I heard that I might go to prison, and because I'm not clear on what I can and cannot do, which is very—

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[164]

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Q. And what about infection, what are you referring to there specifically?

A. Suppose I have a woman who comes in with ruptured membranes and she has an infection, she has what's called septic abortion. It's not induced [165] abortion. It's spontaneous abortion, a septic spontaneous abortion. Septic means that she has bacteria in her blood already from the infection in her uterus.

In those cases, the bacteria grow in the fetus, they grow in the placenta and in the uterus and they make the uterus very infectious. The longer you wait, the more of a chance it is that the mother is going to be really sick and, in fact, die. Septic abortion before abortion was legal was the major—one of the major causes of women dying of an effect from abortions.

Q. You wouldn't do an intact D&E in that circumstance because you wouldn't have to wait two days to have her dilate the cervex, would you?

A. Yes, but they can come in—well, no. Just a second. The waiting to dilate the cervex and the intact D&E are two separate things.

Q. But you were just describing a woman coming in to see you and this was her condition.

A. And she's infected.

Q. And if that is her condition, are you then going to take two days to dilate her cervex to do an intact D&E?

A. I examine her. Her cervex is 3 [166] centimeters dilated. The fetus is there with the breech and the fetus is alive. The safest medical procedure for me, as a physician, to do at that moment is to bring her to the operating room and do an intact D&E because if I use instruments in an infected uterus, I make the whole situation much worse and I can kill her.

The safest thing is to bring her to the operating room, to remove the fetus as I would in an intact D&E, every intact D&E, and decrease the amount of time. If the law tells me I cannot do it, I know I have to do D&E and am forced to do, quote, unquote, the other D&E, which is the dismemberment D&E which increases the risk.

So I'm forced as a physician to do a less safe, in my mind, a less safe procedure for the woman. And in my conscious I can't do it.

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[203]

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Q. Do you think there's any risk presented by the internal podalic conversion?

A. In a term pregnancy there is a risk, and I've done those. I've done many of those.

Q. What about at 23 weeks?

A. If you do it carefully and gently and if it can easily be done, there is a slightly increased risk of perforating the uterus.

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Q. What about at 20 weeks?

A. There is slight increased risk.

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Q. So are you agreeing with Congress's [207] finding that intact D&E poses a risk of lacerations in secondary hemorrhaging?

A. Yes, I agree with that.

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[211]

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Q. In your opinion is intact D&E ever the only appropriate procedure for terminating a pregnancy?

[212]

A. An intact D&E is rarely, if ever, the only medical procedure. But you can say the same thing for nearly every medical procedure that's being done. There's always an alternative to it.

Q. When you say "rarely," can you give me an example of when you think that it would be the only appropriate procedure for terminating a pregnancy?

MS. PARKER: Objection. Vague. Before, you said the only procedure. Now you said the only appropriate procedure. What's the question here?

Q. Did you understand my question?

A. The only procedure, I cannot think of a circumstance where a D&X is the only procedure available.

Q. Can you identify for me any circumstance in which you believe that D&X would be medically necessary to preserve maternal health?

A. D&X is a part of a D&E procedure. There are circumstances, some of which we discussed today, where D&E is preferable over an induction termination of pregnancy. So when we start doing the D&E, I realize that the fetus is presenting with a [213] breech and the cervex is adequately dilated. At that moment I can choose to either do an extraction D&E or a dismemberment D&E. Those are my choices at that moment.

Q. I understand that those are your choices at the moment, and I understand that you make your choice at that moment. But is it ever in your view medically necessary to pick one over the other for purposes of maternal health?

A. I'm glad you bring up this question. We rarely ever have a single procedure that is absolutely necessary. As a physician, I have to choose which one is a better procedure than the other. We always have to make—every time I'm in the operating room, every time I do delivery, I have to choose which one at that moment is the safest possible procedure.

Are there others? Sure there are others. But in my experience, I'm being asked what do you think is best for the patient at this point.

Q. And those safety advantages are the ones associated with less instrument use, less, as you've told me—

A. Less instrument use. No instrument use, in fact. No use of forceps, I'm sorry. No use [214] of instru-

ments which enter the uterus in order to remove the fetus.

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UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

No. 03 Civ. 8695

NATIONAL ABORTION FEDERATION, MARK I. EVANS, M.D., CAROLYN WESTHOFF, M.D., M.Sc., CASSING HAMMOND, M.D., MARC HELLER, M.D., TIMOTHY R.B. JOHNSON, M.D., STEPHEN CHASEN, M.D., GERSON WEISS, M.D., ON BEHALF OF THEMSELVES AND THEIR PATIENTS, PLAINTIFFS

v.

JOHN ASHCROFT, IN HIS CAPACITY AS ATTORNEY GENERAL OF THE UNITED STATES, ALONG WITH HIS OFFICERS, AGENTS, SERVANTS, EMPLOYEES, AND SUCCESSORS IN OFFICE, DEFENDANT

DEPOSITION OF
CASSING HAMMOND, M.D.
Feb. 18, 2004

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[GOWAN EXAMINES HAMMOND]

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[5]

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Q. Okay. First, what I would like to do is get sort of a general understanding of your medical background, where you trained, where you performed your residency, what your specific certifications are.

A. I went to medical school at the University of Missouri at Kansas City and was [6] enrolled in their six-year BA/MD program.

After completing my training in 1988, I moved to Rochester, New York, where I performed my four-year residency in obstetrics and gynecology.

Following my residency training, I was in private practice in Rochester, affiliated with the University of Rochester for three years.

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Q. And then what did you do after leaving [7] Rochester?

A. I left Rochester in 1995 and returned to academic practice here at Northwestern University.

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[8]

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Q. Okay. And so you came in 1995 to Northwestern, and in what position?

A. I was an instructor in the Department of Obstetrics and Gynecology and a member of the Division of General Obstetrics and Gynecology.

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Your CV—it is not a test. And what's on our CV, I was just sort of asking generally. It says August, '95, to July of 2001, instructor in the Department of Obstetrics and Gynecology. And August, 2001, to present, Assistant Professor.

A. Okay.

Q. Okay. Are you still within the Division of Obstetrics and Gynecology as well?

A. Yes, I am.

Q. Okay.

A. I am approximately 60 percent time in the Division of General Obstetrics and Gynecology.

Q. And just very briefly, what are your duties as the assistant professor in the Department of Obstetrics and Gynecology?

[11]

A. I have a variety of duties within that department. Certainly, for 60 percent of my time, I function as a member of the general Division of OB/GYN and see typical obstetrics and gynecology patients, delivering babies, performing surgeries that gynecologists would typically perform and teaching those methods to our residents and our medical students.

Q. How many babies did you deliver last year?

A. I would have to look to be certain, but I often deliver around a hundred babies per year.

Q. Okay.

A. Continuing, I wear several other hats within our department, so to speak. I am director of Prentice Ambulatory—medical director of Prentice Ambulatory Care and Surgery which are the outpatient clinics of our residency training program.

These are also patients who come for general obstetrics and gynecology care but see our residents for their care who are also backed up by a number of attendings within our [12] department.

In addition to overseeing that division, I am director of medical student education at Prentice Women's Hospital site and assistant director of the division of undergraduate education for our department.

This means that I coordinate medical student education for third-year medical students who are in our department.

I am also the gynecologist for the HIV program at Northwestern Memorial Hospital. I am one of the gynecologists at the Rehabilitation Institute of Chicago, and I am director of Northwestern's program in family planning and managing director of the fellowship in family planning.

Q. How many fellows do you have in your family planning program?

A. We currently have two fellows. We accept one fellow per year.

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[13]

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Q. What percentage of your time is spent as the director of the Northwestern family planning program?

A. It's hard to say an exact percentage. At least 20 to 30 percent of my time is spent either managing the program or performing clinical responsibilities related to the family planning program.

Q. What's the patient population of the Northwestern family planning program?

A. The patient population of the Northwestern family planning program consists of [14] those patients for which I am responsible at Prentice as well as patients with whom our fellows might interact at other sites. I am not involved with those sites.

At Prentice, our patient population consists predominantly of women who are referred to myself for

pregnancy termination procedures, most commonly procedures that are needed either based on maternal health or fetal indications.

Q. When you say that the patient population includes those patients that you have at Prentice, are you referring to patients in connection with your position as the medical director of the Prentice Ambulatory Care Clinic?

A. Not directly.

Q. Okay.

A. The patients who are part of our family planning program are really referred from throughout our institution and also from throughout this area.

We have patients who are in need of pregnancy termination services who cannot obtain them in other parts of Illinois or at other institutions within Chicago. And we receive [15] referrals routinely from a variety of physicians whose patients need our services at those other institutions.

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[18]

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Q. I see. What types of abortion services do you provide?

A. I provide abortion services for patients referred to us through the family planning service. Some of those patients are requesting pregnancy termination for "elective reasons." We perform those predominantly in the first trimester and not after 16 weeks' gestation.

The majority of the referrals that I receive are for patients requiring termination due to maternal and fetal indications, by which I mean maternal illnesses and also fetal anomalies or other problems of a troubled pregnancy.

Because many providers do not provide [19] services in the second trimester, a large number of our referrals are for patients who need these terminations in the second trimester of pregnancy.

Q. And what gestational age do you provide services for beyond 16 weeks?

A. We provide pregnancy termination services for maternal-fetal indications through 24 weeks' gestation.

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[23]

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Q. And can you give me an idea of the types of referrals that you receive for maternal terminations for maternal indications?

A. We see a large number of maternal indications.

Q. I'm sorry. When you say "we," who are you referring to?

[24]

A. I am referring to the service at Northwestern.

Q. Okay.

A. The family planning program.

Q. Okay. Thank you.

A. The family planning program receives referrals for women with a variety of illnesses. As I stated in my declaration, I have had patients with malignancies such

as leukemia, breast cancer, and other malignancies who have requested or required termination.

I receive patients with intrauterine infections which is called chorioamnionitis who require termination on this basis, something that could be considered both a maternal or even fetal indication. I am—

Q. Why is that? How is that considered a fetal indication?

A. I think that the risk to the pregnancy, particularly the mother, is so great at this point that the pregnancy must be terminated.

Q. If the risk to the mother is so great that the pregnancy has to be terminated, how does [25] that make it a fetal indication?

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. Because chorioamnionitis is an infection of fetal material. It is an infection of the placenta and amniotic membranes.

BY MS. GOWAN:

Q. I see.

A. Therefore, it is indicated based on a fetal condition that is now jeopardizing maternal health.

Q. Thank you. What other types of conditions have you—maternal indications have you received referrals for while you have been at Northwestern?

A. I have had mothers with cerebrovascular abnormalities including aneurysms and brain tumors who have required termination.

I have had patients with very early forms of preeclampsia/HELLP syndrome, H-E-L-L-P, who have required termination.

I have had people with liver failure needing transplant who have required termination. I have had patients with very [26] severe diabetes, very severe coronary artery disease, whose doctors have recommended that they terminate pregnancies.

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[27]

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Q. Well, I am asking are some of these your own patients, or are some referred to you by other obstetricians for the purpose of performing the termination?

A. I have patients like any obstetrician who will ultimately develop maternal health [28] issues or who are diagnosed with fetal anomalies. And certainly, if they are my own patient, because I am one of the few obstetricians who is on faculty who has the skills required to perform the termination, I will do so.

I would emphasize that the majority of the procedures that I am doing are referred by other obstetricians. And the majority of the patients, because of the complexity of their medical—excuse me, of their maternal medical or fetal issues, have already been counseled by a number of physicians before they come to my practice.

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[41]

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Q. Okay. In the 20- to 24-week gestational age, can you give me an idea of what the percentage of the terminations you provide are by D&E?

A. At least 95 percent or more are by D&E.

Q. And what are the remainder? What's the method in the remainder?

A. Induction of labor.

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[47]

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Q. Okay. And what do you mean when you say that where the fetus is living, the period of time is less predictable?

A. I mean that the induction abortion time cannot necessarily be predicted, meaning that some patients might deliver within 24 hours, but one of the sad consequences of medical induction of labor in the second trimester is occasionally, a patient will undergo attempted induction for one or two or even three days, still without successfully aborting the pregnancy.

Q. How often does that happen?

[48]

A. I cannot give you exact percentages.

Q. I am not asking for exacts. I understand that you can't. I am asking for an idea.

A. I can't tell you—I cannot tell you for living fetuses how often the induction abortion time exceeds 24 hours.

However, I am consulted for this on probably at least a monthly basis by members of our Maternal-Fetal Medicine Division.

Q. When you say you are consulted on this, what do you mean?

A. As I mentioned earlier, many of my referrals come from our Division of Maternal-Fetal Medicine, so if they have a patient who is on the labor floor at Prentice or if somebody else at an outlying hospital has had a patient who for whatever reason has decided to undergo a medical induction of labor, and it has failed, and the patient is still unable to abort, they will then consult me to reconsider the method of abortion that was originally planned.

Q. Okay. And that occurs about once a month?

[49]

A. At least.

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[63]

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Q. Okay. So let's talk about 20 to 24 weeks.

A. The procedures are all similar in that the process begins with cervical preparation.

Most commonly, cervical preparation is [64] achieved by placing a form of osmotic dilator into the cervix on the day or two before the actual uterine evacuation occurs.

The most common form of osmotic dilator that we use are called laminaria which are a form of seaweed.

We have a protocol that we again vary according to patient, but in which we put varying numbers and sets of laminaria, dependent on the gestational age of the patient who is undergoing the D&E procedure.

Q. Okay.

A. Beginning 24 hours before the procedure is performed.

Q. Okay. I really want to know from 20 to 24 weeks, so tell me what are the varying numbers at that gestational age.

A. At 20 to 24 weeks, we typically place two to three sets of laminaria tents. Typically, after seeing and counseling the patient, we place a first set of laminaria.

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[65]

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Q. Well, you were telling me about cervical preparation at 20 to 24 weeks, and we were talking about the use of laminaria tents.

A. Would you like to know our protocol at [66] 20 to 24 weeks for laminaria?

Q. Well, that's what you were telling me about.

A. Well, I can tell you our protocol is to place two or three sets of laminaria tents. These typically begin 24 hours before the D&E procedure.

After we have counseled the patient, the first set is placed. Later that afternoon, usually at least six to eight hours later since laminaria require four to eight hours to achieve dilatation, the patient returns, we take out the first set of laminaria and put in a second set.

Occasionally, depending on the clinical circumstances of the patient, we are able to achieve an adequate number of laminaria and adequate cervical dilatation that a second set will suffice for the procedure the next day. And in that case, no further sets are required.

Quite often, however, in patients between 20 and 24 weeks, a third set is required, in which case the patient returns the morning before her surgery which is typically at least four hours after this set and receives a third [67] set of laminaria tents.

Q. How often—and when you say typically a third set is required, how often is a third set required in your experience?

A. Without attempting to evade the question, it is very difficult to answer because there are so many variables that play into this, and we are seeing such an unusual non-homogeneous population of patients.

If the patient, for example, is multiparous and has had children before, her cervix will often be more pliable, and we will often be able to avoid the third set of laminaria.

If she, however, is nulliparous, has not had children before or simply has a more recalcitrant cervix, we may require the additional set.

Q. Is the process ever more than 24 hours before D&E in your practice?

A. Rarely, but occasionally, depending on the nature of the cervix. One of the things that I insist on with my residents and fellows is that we not perform the procedure until the cervix is [68] adequately treated, and if this requires waiting longer, then we

wait longer. It is exceedingly rare that this is the case, period.

Q. You have placed the laminaria, you have put in the first set, the second set, and the third set if required, and now, you are in the operating room. What do you do?

A. The first thing that we do—let me back up. Are you speaking only still about 20- to 24-week terminations?

Q. Yes.

A. Once we have arrived in the operating room, the patient is placed under general anesthetic. Once she is asleep, we place the patient in dorsolithotomy position, remove the laminaria, and I assess whether I think cervical dilatation is adequate.

Q. How do you do that?

A. I do so by feeling the cervix, checking not only dilatation, but also the softness of the cervix.

Q. Do you use an instrument to assess the cervix?

A. No, because the most appropriate way [69] at-least initially is by digital exam to feel the softness since a mere assessment of dilatation often doesn't tell you this.

Q. Do you ever use an instrument to assess the cervix?

A. Immediately before beginning the procedure, I will make sure that the instruments that I think I might need easily pass through the cervical os.

Q. And how do you do that?

A. After we have removed the laminaria, prepped and draped the patient, we grasp the anterior lip of the cervix with some type of tenaculum or other grasping device so that we can stabilize it during the procedure.

We then either pass a dilator through the cervical os or one of the common extraction devices through the internal os to make sure if there is any remaining question in our mind that the cervix is adequate.

I want to emphasize that we are not dilating and stretching the cervix at this point. We are only doing this in cases where we think we need to be absolutely more certain than [70] we were able to ascertain by digital exam that the cervix is adequately prepared because I never wish to start a procedure until I am certain that that is the case.

Q. So are you saying that you don't always use an instrument to assess whether the cervix is adequately prepared?

A. We very often do not need to. Depending on the nature of the pregnancy that is undergoing termination and the nature of my digital exam, I may well know immediately before the procedure based solely on digital exam that the cervix is adequately dilated.

Q. Do you know that in the majority of cases, based on digital exam?

A. Not necessarily. And I can't give you an exact percentage how often that is the case.

Q. I know you can't give me an exact. I am asking for a general idea. So do you use instruments to assess half of the time, or do you rely on your digital exam most of the time? Can you give me an idea?

A. I think that my digital exam is the most important determinant of my comfort [71] proceeding with D&E in at least 80 percent of cases.

And it is one reason whenever I operate with residents and fellows, that I am the only person who initially does the digital exam because I consider this so critical to determining my ability to perform the procedure and because it is something that is so dependent on the gestalt of the operator.

Q. Has your reliance on your digital exam for assessing cervical preparation increased over the years that you have been practicing and gaining experience with the procedure?

A. I was trained to check the cervix digitally and have always relied on this portion of the preoperative evaluation.

Q. What size instruments do you use in those cases when you assess with instruments?

A. We use the same instruments that we use for all of our D&Es.

Q. Are the instruments that you would use for the D&Es different at 20 weeks than they are for 24 weeks?

A. No, they are not. They are the same.

[72]

Q. And what instruments are you referring to?

A. We have a variety of extraction forceps. Hern forceps, Sopher forceps—Hern, H-e-r-n; Sopher, S-o-p-h-e-r; Bierer, and I hope I get this right, B-i-e-r-e-r; Vanlith, V-a-n-l-i-t-h, and others that are available.

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[73] * * * you are making your cervical assessment just prior to beginning the procedure?

A. We would not do this just prior if you mean immediately at the time when we are in the operating room with the patient asleep.

Q. Yes.

A However, we have used misoprostol for further cervical preparation. The most likely time that we would use misoprostol is in a patient who has a recalcitrant cervix who still has a very tight cervix during placement of a third set of laminaria the morning before her procedure.

Q. Do you ever use any mechanical dilators at the time that you are in the operating room to achieve greater dilation prior to commencement of the procedure?

A. We do this in first trimester procedures.

Q. I'm talking 20 to 24, Doctor.

A. It is very rare that we ever use [74] additional mechanical dilators. I do have some called the Hern, H-e-r-n, dilators, which can achieve significant dilation. In my experience, they have not been particularly helpful, and I am far more concerned that I achieve adequate dilation before I ever start the procedure which is one reason that I am so insistent that I digitally check the cervix each time before we start.

Q. What does the Sopher forceps look like?

A. The Sopher forceps is a serrated grasping instrument made of metal with a slightly rounded tip.

Q. Is the serration on the inside of the forceps?

A. Yes, it is on the inside of the forceps.

Q. And what is the outside of the forceps like?

A. It is a relatively smooth outside.

Q. And is that so when you put it into the woman's uterus, you are not—you won't mistakenly lacerate the uterus, or let me—do [75] you know why it is designed —try it again.

Do you know why the Sopher forceps is designed to be soft on the outside?

A. I think it is soft on the outside because if you had serrations or anything else, it could scrape the cervix and result in an injury.

I dislike the first way that you asked that question because laceration of the uterus is a very uncommon outcome of D&E and is best avoided by having a skilled operator.

Q. Okay. Is the Hern forceps also soft on the outside?

A. It is made of metal, but there are not serrations.

Q. "Smooth" is perhaps a better word than "soft"?

A. Smooth, yes.

Q. Okay. And is the Bierer forceps also smooth on the outside?

A. Yes, it is smooth on the outside.

Q. And the same with the Vanlith?

A. Yes.

Q. I don't want to discuss this at [76] length, but can you just very briefly tell me what the difference is in these different kinds of forceps?

A. The forceps—at Prentice, I have access to all of these different forceps for every D&E that I perform at all the gestational ages that I perform them. There are cases where some of the forceps may have certain advantages.

Q. Okay.

A. That are not necessarily related to gestational age.

Q. Why don't you tell me what some of the advantages of the different forceps might be?

A. The principal advantage of the Hern forceps are that the fulcrum of the Hern forceps * * *.

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[77]

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Q. Okay. Going back to you're describing the procedure for me, you have done your cervical preparation, the woman is in the operating room, you have performed your digital exam to assess the cervix, and if necessary, you have passed an instrument to insure that you have appropriate dilation. What happens next?

[78]

A. In most cases, the next step involves evacuating fluid from the uterus. I say "in most cases" because again, we see a very unusual population of patients including patients where there may be no amniotic fluid to evacuate. And in those cases, we obviously omit this step.

We typically place a 12-millimeter suction curette into the uterus and suction evacuate as much amniotic fluid as possible.

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[81]

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Q. Okay. All right. You cut the cord, if that was possible. And you were just about to tell me about your work with the instruments.

A. At this point, we reach inside the uterus with an extraction forcep. Largely dependent on feel of the operator, we grasp a presenting part. Most commonly, we will grasp a lower extremity.

The object of the D&E is to evacuate the uterus with the fewest number of passes possible. This entails grasping as much of the fetus as we can, extracting those portions of the fetus with repeated insertions of the extraction forceps and then or at some point along this process, extracting the placental material.

Q. You grasp the fetal leg. What do you do?

A. We pull.

[82]

Q. Okay.

A. When we grasp the fetal leg, we try to pull as much of the fetus out as we possibly can at this point.

Quite often, we will meet resistance at the internal os of the cervix because that is typically the smallest diameter that the fetus has to traverse as it exits the uterus.

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[95]

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Q. Okay. I noticed in the documents that you produced that you had Dr. Haskell's paper that was presented at that seminar. And in that paper, he refers to something called a "classic D&E." But apart from—did you notice that in his paper at all?

A. I have noticed Dr. Haskell's assertion that there is some distinction between D&Es in which the fetus is extracted more intact than in others, but I thoroughly disagree with the [96] concept that this constitutes a separate and distinct procedure.

Q. Why?

A. Because a D&E is a D&E is a D&E.

Q. Any other reason?

A. That is a very critical, crucial reason. All that Dr. Haskell has really done is to describe an evolution of standard D&E, a procedure that we have become familiar with during nearly 30 years of its evolution.

I do not believe the distinction of classic, traditional, or other methods of D&E really are describing a difference of intention or a difference in procedure, a difference in even philosophy than the majority of D&E providers have already initiated as part of their practices.

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[112]

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Q. Before we took the break, Doctor, we were talking about those circumstances in which [113] the fetus was demised.

Have you ever had the occasion, in connection with performing a D&E at 20 to 24 weeks, to reach with your instruments and extract an intact living fetus up to the point where the head gets stuck in the internal cervical os?

A. Yes.

Q. Okay. And how many times has that happened?

A. I cannot tell you a number.

Q. Is it a large number?

A. I'm not going to be able to give you a number. Inherent in all D&Es as I have stated is an attempt to extract the fetus in the fewest number of passes possible to minimize maternal risk, so if I am able in confronting a fetus and demise has not occurred to reach in and extract at least that far, I will do so. And it does happen on occasion in our operating room.

Q. Okay. Can you give me an idea of how many times it has happened to you?

A. I would say that we have at least, at least three times per month when we are in a circumstance such as this.

[114]

Q. Why do you try to minimize the number of passes?

A. Because logically, the more that you have to traverse the cervix, the greater the likelihood with each of those passes that you can traumatize the patient, so if we minimize the number of times that we are having to put an instrument in, feel in the uterus and extract parts, we are decreasing the likelihood, the number of

chances we take of perforating the uterus and of injuring the cervix.

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[145]

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Q. Again, I am trying to understand what you are describing. You were telling me about being stuck at the umbilicus.

A. The situation that I am describing is when the umbilicus has descended past the external os so that I can see the umbilicus has passed through, and I basically have the abdomen stuck at the level of the cervix.

Q. Okay. Now, what do you do to remove the remainder of the fetus in that circumstance?

A. We will in some cases make an incision [146] immediately inferior to the fetal umbilicus.

Q. What does "inferior" mean?

A. Immediately beneath.

Q. Okay.

A. Towards the—not to confuse us, but towards the extremities, that direction.

Q. Okay.

A. So we will make it immediately beneath the fetal umbilicus. And what this does is to also decompress. It gives us more room because any intra-abdominal contents are then able to extrude through the fetus, allowing me perhaps to be able to then regrasp the fetus superior then or higher on the fetus and continue the process of effecting as facile a delivery as possible.

Q. It may or may not then get stuck at the neck?

A. That is correct.

Q. Okay. Now, is there fluid in the abdomen that you are extruding?

A. Is there fluid in the fetal abdomen?

Q. Yes. You said that you would—well, I don't think you used the word "puncture," but that's the idea, right, you would puncture, and [147] then something would extrude. What is it that—

A. Well, it varies.

Q. I'm sorry?

A. Because keep in mind, I am doing these on fetuses that are often very anomalous.

Q. Okay.

A. And so if you ask could there be fluid, absolutely. We have deformities that have been sent to us where the fetus has significant ascites which by definition is abdominal fluid.

But in other cases, it is simply the internal abdominal viscera, the intestines, perhaps kidneys.

And again, the patients that I am seeing, oftentimes, there are fetal anomalies where the abdomen may actually be significantly enlarged precisely because of abnormalities with these viscera, so allowing them to extrude, taking advantage of the extra room we have in the vagina, may allow us then to complete more of the procedure intact.

Q. Got it. So at the point that you are puncturing the abdomen, the abdomen is still in the vagina, is that right?

[148]

A. It varies. And I can't answer that because again, different women are shaped differently. There are different degrees of pelvic descensus. And you could have a case if the cervix is immediately at the vaginal entroitis, where the abdomen is actually outside of the entroitis.

In other cases, if you have a patient with a prolonged vagina or who is just obese and you have a prolonged distance from the cervix to the entroitis, or in that case, yes, the abdomen is inside the vagina.

Q. How often has it happened that when you puncture the abdomen, that the umbilicus has been outside of the vaginal entroitis?

A. Once again, I have trouble giving you a number. I know—

Q. Well, has it ever happened?

A. Yes, it has happened that this is the case. And I cannot give you a precise estimate.

Q. Would that puncture effect fetal demise?

A. I think it's clear that extracting all of the fetal abdominal viscera will at some point [149] effect demise.

Now, if you are asking how long it would take, I can't answer that. I don't think I know. But I know if I do make an incision and carry out this act, that it will eventually at some point result in fetal demise.

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[157]

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Q. Have you ever perforated a uterus in connection with a D&E by disarticulation?

A. Well, I am confused somewhat by "D&E by disarticulation" because to me, all D&Es are essentially the same. And most will involve some type of disarticulation, depending how you define that term.

Now, if you are asking have I had a uterine perforation, yes. Anyone who does enough of those procedures will have a uterine perforation.

And one of the things that I tell my patients is that if they are going to a provider who has not at some point in their training or practice had a uterine perforation, they are going to the wrong provider because that person is probably not doing enough D&Es, and they also don't know how to deal with a complication when [158] it arises.

Q. How many times has uterine perforation been a complication in a D&E that you have performed?

A. I couldn't say, but it is a rare complication. And I would say even in the course of the nine years that I have been at Prentice, it is fewer than ten times, so it is an exceedingly rare event.

Q. Do you know whether any of those times where that complication occurred, that you had performed—you had been able to extract the fetus intact up to the point where the head was stuck in the cervical os?

A. I know that that has never happened to me in those cases. In fact, one of the advantages of a D&E that allows you to proceed in a more intact fashion and one of the advantages of one such as you have described where the calvarium is above the internal os and some or part of the fetus remains below is you have greater

control and I believe probably less likelihood of perforation. I have not had one under those circumstances that you have [159] described.

Q. Do you consider a D&E where the fetus is not extracted intact up to the point of the head which is stuck in the cervical os to be a safe procedure?

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. I would make clear that I consider a D&E in which the head is not delivered up to the—where the fetus is not delivered such that the head is trapped above the internal os as you described, that I consider those D&Es and other relatively more intact D&Es part and parcel of the same procedure, and I consider all of them safe procedures.

BY MS. GOWAN:

Q. Have you ever studied the advantages or I should say compared and performed a study that compares in some way the advantages and the disadvantages that you have described to me today of an intact removal up to the point where the head is stuck in the cervical os, vis-a-vis not having an intact removal of the fetus up until that point?

[160]

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. Again, I don't believe that the procedure you are trying to distinguish is really a distinct procedure from those involving disarticulation. They are part and parcel of the same group of procedures which have been studied at length for 30 years.

I think that designing a study that looked at varying degrees of "intactness" would be incredibly difficult if not impossible to perform for at least two reasons: one reason is that D&E overall is an enormously safe procedure. And if you study any type of D&E, you have to have so many patients enrolled to be able to achieve statistical power to show meaningful differences between bad outcomes that it becomes very, very difficult to study the outcomes that are really in question.

For example, we would like to know how certain types of procedural variations might affect rates of uterine perforation, but uterine perforation is so uncommon, we usually in studies of D&E can't use that as an end point, so people [161] look at secondary outcome variables such as blood loss or OR time which aren't really as meaningful to the operators themselves.

The other problem with a type of study that you suggest is that because these are not distinct procedures, we cannot prospectively allocate patients to an intact or partially intact group versus a disarticulation D&E. The procedures do not exist separately from one another.

By that, when I begin to do one of these procedures, I am at the mercy of the cervix, the mercy at the vagaries of the cervix. I can't always tell simply by checking dilatation because it is also a functional acquiescence of the cervix. And the degree of intactness is to some extent what I get.

I know that I want maximal intactness because that follows based on common sense and certainly in my experience is safer, but designing a study to show it I

think is going to be very, very difficult, if not impossible.

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[169]

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Q. Okay. Why don't you do the injections?

A. There has not been a need in my department for me to do the injections.

First of all, we do have other people in the department who are able to do this and do so more frequently. I also do not believe that the injections are commonly warranted before abortion procedures.

Q. Why is that?

A. In order to commonly warrant an additional procedure, there would have to be some benefit that would justify a maternal risk.

I will grant that the maternal risks of giving a feticidal intracardiac injection are low, but there are still minor risks, and it is still an additional procedure.

[170]

The question, therefore, is what is the benefit that would justify doing this and particularly doing it on a routine basis. There probably is no such benefit.

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[186]

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Q. Have you observed a fetus that was born alive after induction abortion, second trimester?

A. In the course of my career, yes.

Q. What did you observe in terms of signs of life from the fetus?

A. Typically after the fetus is born, you may see spontaneous respiratory activity, you may observe a heartbeat. Occasionally, there will be what appear to be spontaneous movements. All of this depends on the gestational age of the fetus that is involved.

Q. Have you observed that at 24 weeks?

A. I have observed fetuses delivered at 24 weeks who exhibit all of those signs. And as I just testified, if I were doing a delivery of a * * *.

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[192]

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Q. Yes.

A. And I have had case—a case in which two twins were—two fetuses were conjoined and another was distinct.

And in this case, we felt that proceeding with an induction was relatively contraindicated, based on the type of conjoined twins that we were dealing with.

This was the opinion of maternal-fetal medicine specialists in my department and was one reason why we counseled the patient that D&E might be preferable.

Q. In that case that you just described to me, was either of the fetuses extracted intact up to the point where the head was stuck in the internal cervical os?

[193]

A. Well, that's one of the problems with this legislation is I think encapsulated in that very question.

Because fetuses that are conjoined such as this are not conjoined in the predictable fashion nor extracted in the predictable fashion that we might with a singleton pregnancy, I can't tell you how intact these fetuses were extracted, nor can I in terms of how this law defines an intact dilatation.

For example, the law that's in question would describe an intact dilatation as one in which any part of the fetal trunk is delivered above the level of the fetal umbilicus or navel, without demise having occurred.

And in the case of conjoined twins, it is conceivable, though I can't remember the exact extractions in this case, that I could easily grasp something above a fetal umbilicus or have extracted part of one twin to the level of the calvarium where the other remained inside.

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[195]

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Q. Do you think that D&E is safer than induction abortion at all gestational ages [196] beginning at 20 weeks going forward?

A. I think for those gestational ages that I perform, at 20 to 24 weeks, it is at least as safe and potentially safer.

I don't know that we have data substantiating that it is safer to the extent that we do with earlier second trimester abortions, but certainly, we have data that D&E at these gestational ages is safe.

Q. So you are saying at 20 to 24 weeks, the two are comparable in terms of safety? Am I understanding you correctly?

A. I think the two are at least comparable, and that based on data we have from earlier in gestation, we must assume that D&E, which is essentially the same procedure after 20 weeks as it is before 20 weeks, is at least as safe and maybe safer.

Q. When you say "we must assume," are you saying you, Dr. Hammond, assumes, or are you saying that the medical profession at large assumes that and it is written somewhere?

MS. CHAITEN: Object to the form.

BY THE WITNESS:

[197]

A. I am saying that we, the medical profession, and particularly those of us who practice in institutions that have competent, trained providers of second trimester abortion, have to assume that in skilled hands, this procedure is at least as safe.

BY MS. GOWAN:

Q. And you certainly assume that, right?

A. About myself or about—

Q. Yes, yes.

A. I assume that D&E between 20 and 24 weeks in my hands is at least as safe as inducing labor.

Q. Okay. Are there any specific conditions, fetal indications in which you believe that the intact D&E procedure would be specifically indicated?

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. I don't believe that there is an intact D&E procedure. And as I have testified, a D&E is a D&E. And I don't believe that the procedure really varies that much differently regard—regarding the specific fetal anomaly.

[198]

My intent with every D&E is the same, and that includes attempting to do the procedure as intact as possible.

BY MS. GOWAN:

Q. What, if anything, would you do differently if the law was upheld?

A. That's a difficult question because I want to obey the law.

On the other hand, I don't really know how we can have a law such as this one that fails to define the type of procedure it outlaws more specifically and that also fails to include a health exemption and still permit me to practice safe medical care or at least the safest medical care for my patients.

Q. Well, I understand that that's your view, but I am just asking you to assume for the moment that the law will be upheld. And what, if any—if at all, would that change your practice?

MS. CHAITEN: Object to the form. Asked and answered.

BY THE WITNESS:

A. I am afraid if this law is upheld, [199] that we will be compelled by the law to subject women to risk which they do not deserve to be subjected to. I think

this law has the potential to cause great harm to women, and that's one reason why I am here testifying.

BY MS. GOWAN:

Q. Can you tell me any concrete way in which—and maybe there isn't, and you can tell me that if there isn't—in which you feel that you would have to change the way you perform D&E if the law were to be upheld?

MS. CHAITEN: Object to the form. Asked and answered.

BY THE WITNESS:

A. Well, that opens up a wide array of things which I think we have been talking out—about throughout the day.

This law, first of all, is too vague. And as I have been testifying, it attempts to create a procedure that does not exist in medical practice. There simply is no procedure called partial-birth abortion.

And this law attempts to define the procedure in different ways. In its finding [200] section, it mentions, it alludes to several discrete steps and gives a definition and then doesn't allude to all of those same factors when it actually states the ban later on.

I believe that the way—and this is going to be a long answer because it is a long question—I believe that this law could potentially affect every D&E that I do because as I have mentioned time and again today, every time I sit down to start a D&E, I want to get appropriate dilatation, do the procedure as intact as possible, and I don't know a priori that I might not inadvertently do an extraction that qualifies through somebody's interpretation as being what this law specifies as outlawed.

So to the extent it is going to proscribe what 30 years of data has now documented as the safest method of terminating pregnancies, it will place my patients at risk, and by criminalizing it for me, will have certainly a chilling effect that may prohibit people like me from even taking the risk to give our patients the best medical care.

Without a health exemption, this law [201] also will place my patients at risk because as I have testified, I see patients who are terminating pregnancies because of their own health issues or fetal health issues. In many of these patients, this is the safest procedure that they can possibly undergo.

BY MS. GOWAN:

Q. Well, if the law is upheld, will you stop doing D&E?

MS. CHAITEN: Object to the form. He testified he doesn't know what he would do.

MS. GOWAN: I don't think he said that.

BY MS. GOWAN:

Q. Is that what you—you don't know what you would do if the law—you don't know how you would change your practice, if at all, if the law were upheld?

A. I think that I have testified that I don't know what we would do because I don't know what I would do because I want to obey the law, but this law is so non-specific, I don't really know what the law is outlawing.

Q. Okay. So you might change your practice, you just don't know what you would do?

[202]

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. Well, and I think it is very difficult to ask a doctor if they would change their practice when they know that implementing those changes in their practice is going to harm their patients.

And make no mistake about it, if this law is passed and allowed to stand as is, doctors will necessarily have to take actions to protect themselves from violating this law that could place patients at risk.

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[233]

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Q. Has any patient ever asked you [234] specifically not to extract the fetus, her fetus to the point of the neck and then puncture the back of the neck and suction the contents of the calvarium?

A. No, but ironically, we have had patients specifically ask if we could do the procedure as intact as possible, that they would prefer it.

In fact, we had a patient just last fall who specifically requested this because she had a family member who was an obstetrician, had been aware that there were places trying to do this procedure intact, and she wanted to be able to hold the fetus after the delivery. And fortunately, we were able to do so for her.

BY MS. GOWAN:

Q. Why do you know didn't that woman select induction abortion?

A. Because she had a family member who was an obstetrician. And he realized that a D&E is still the safest procedure for his wife in this case.

Q. Did he tell you that, or you are just assuming that was why?

[235]

A. No. We were told this.

Also, many patients, once they hear descriptions of induction terminations and realize that they may confront not a few hours of induction but as we discussed earlier, one day or two days or three days of induction, immediately find it psychologically compelling to proceed with a procedure that can usually be accomplished in approximately 15 minutes, excluding the cervical preparation time.

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[316]

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Q. Do you do the internal podalic conversion?

A. Internal podalic version to most obstetricians and in most obstetric textbooks refers to a procedure that is performed in fetuses at or near term to deliver a living baby. It does not refer to any type of procedure that would be done during a dilation and [317] evacuation.

Q. Do you ever—

A. So I do occasionally, as anyone doing D&E does, convert a fetus that is vertex to a fetus that is breech. That's very commonly accomplished during D&E because as I indicated, the extremity is the easiest portion of the fetus to control.

Fortunately, we have 30 years of data substantiating the safety of this procedure and know that unlike internal podalic version at term, this is a safe procedure in these cases.

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[325]

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Q. So will cutting the cord in your view always be an overt act within the meaning of the Partial-Birth Abortion Ban Act of 2003?

A. I am uncertain whether it will always be an overt act, but I am certain that in some cases, it could be interpreted to be an overt act.

Q. Okay.

A. And I'm afraid might trigger the ban.

Q. Can you tell me what those circumstances might be?

A. I believe it would be triggered in a case, albeit a rare case, in which the fetus is presented vertex, has delivered the vertex vaginally, and an operator, in an effort to assist delivery, cuts the umbilical cord to permit further delivery.

This might happen, for example, even in an induction termination in which an operator encounters a tightened umbilical cord and needs [326] to cut the cord to extricate the fetus.

I believe it might also be triggered in cases of a breech presentation in which the operator has effected delivery with any part of the fetus exposed above the navel and then cuts the umbilical cord because I know that cutting the umbilical cord will eventually result in

fetal demise and could be interpreted as the overt act that the ban describes.

Q. The latter scenario that you have just described, were you imagining that the head was still lodged on the other side of the internal cervical os?

A. This could be one case.

However, the ban only specifies that the operator has delivered—and let me be careful of my wording—the ban states that any part of the fetal trunk past the navel is outside the body of the mother, so with an understanding of my concerns about the phrasing "outside the body of the mother" which I think we have already detailed adequately today, are more vague than they seem perhaps to a layman who does not do these procedures.

[327]

I believe that if I had delivered such that a part of the fetus above the navel were anything that would meet that definition and then cut the umbilical cord, I would be at risk of considering having violated this ban.

Q. In the context of the induction abortion—well, first of all, do you think the Act covers induction abortion?

A. Unfortunately, the Act is so badly worded, I think that it could be construed in such a way to include some induction abortions.

For example, under the section, "Partial-birth abortions prohibited," Section 1531, item (b)(1)(A), it says that, "The term 'partial-birth abortion' means an abortion in which the person performing the abortion—(A) deliberately and intentionally vaginally delivers."

An induction abortion is deliberate and intentional. The premise, the notion that this is somehow a natural event is fallacious because you are giving medicine to effect this delivery. Therefore, an induction termination is deliberate and intentional vaginal delivery of a [328] living fetus.

The ban then goes on to say in the case of a head-first presentation, the entire fetal head is outside the body of the mother.

Now, I have already I think more than covered my concerns about "outside the body of the mother."

But let's just imagine for a moment that a patient is on the labor floor who has been diagnosed with Trisomy 13, she is 18 or 20 weeks' gestation, and for whatever reason, does not wish to undergo a dilation and evacuation, and therefore, her obstetrician is inducing labor to cause abortion.

Let's assume that they effect delivery, but the fetal vertex delivers past the cervix and is entrapped by the umbilical cord. Admittedly, this may not be a common scenario, but my concern as an obstetrician isn't what's common, it's what could subject me to criminal prosecution, and in this case, what could subject obstetricians to even think they aren't violating the ban to prosecution because of the inept phrasing that is encompassed in this ban.

[329]

I think that if an obstetrician, despite the best of intentions of obeying the law in this case, cut the umbilical cord, there are people who might assume they had then performed the overt act that triggered the ban because they have deliberately, intentionally, vaginally delivered this infant. The vertex is beyond

the body of the woman, whatever that means, and they have now performed an overt act that they know at some point will trigger the demise of the infant.

Q. You don't know what "outside the body of the mother" means?

A. No.

MS. CHAITEN: Object to the form.

BY THE WITNESS:

A. And I think that we have stated this on several occasions, though I am happy to review it again.

BY MS. GOWAN:

Q. No, that's fine. If you just say no, I understand. It seems to me that you don't understand what "outside the body of the mother" means, is that right?

[330]

MS. CHAITEN: Object to the form. There has been a long discussion about this already today.

BY THE WITNESS:

A. And I will simply add as I have said on many other occasions previously today, that my understanding reflects an understanding of the functional anatomy that may not be apparent to people who don't do these procedures and perhaps a more realistic appraisal than the average layman would have of just how vague and just how difficult the term "outside the body of the mother" is actually to be defined in the context of some deliveries and in the context of the procedures that I do.

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[333]

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Q. If you wanted to reduce the degree of dilation of the cervix, could you do that by inserting a lesser number or a smaller laminaria?

A. Not necessarily. It's wrong to assume that this process is within our control to that extent.

When I place the laminaria, they aren't simply pushing the cervix open as we so commonly describe.

The laminaria are more complicated than that. The laminaria are actually changing [334] the cervical ground substance. They are changing the chemistry of the cervix, softening the cervix in addition to facilitating its dilatation.

Therefore, if I have a patient through whose cervical chemistry and parity is particularly amenable to the effect of laminaria, a small number of laminaria may actually effect great cervical dilatation.

Similarly, there are other patients whose cervical chemistry, parity, and other personal issues make her particularly more recalcitrant to the effect of laminaria.

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UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

No. C 03-4872 PJH

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. AND PLANNED PARENTHOOD GOLDEN GATE, PLAINTIFFS

v.

JOHN ASHCROFT, ATTORNEY GENERAL OF THE UNITED STATES, IN HIS OFFICIAL CAPACITY, DEFENDANT

DEPOSITION OF
CHARLES J. LOCKWOOD, M.D.
Feb. 17, 2004

APPEARANCES:

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* * * * *

[GOWAN EXAMINES LOCKWOOD]

[4]

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CHARLES J. LOCKWOOD, M.D., residing at 33 Liberty Street, Madison, Connecticut, being first duly sworn, as hereinafter certified, was examined and testified as follows:

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[15]

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Q. What had you heard about either Dr. Westhoff or Dr. Chasen?

A. That they were very accomplished, particularly Carolyn, very knowledgeable in this area, and very well respected.

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[23]

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Q. You don't have to read anything into the text if you don't want to.

A. I am going to comment on it, if that's all right with you.

Q. That's fine.

A So I think all that is valid and continues to be valid. "Unfortunately, the Act's language is so imprecise that it doesn't just prohibit that incredibly rare and truly horrific procedure, but also threatens all abortions." Let me stop there.

[24]

So this is a key issue obviously. I don't need to tell you that, and that is the issue of the vagueness of the Act. In my opinion, the wording of the Act is such

that I certainly can understand why the plaintiff's experts opined as they did in their expert reports.

Subsequent to writing this, I read the report to the judge that Ms. Gowan and her colleagues prepared. That raised the issue of intent and so here in fact is how my views have been modified.

So the issue is if the intent of the practitioner at the beginning of the procedure is to do a D&E and the procedure, through no fault of her or his efforts, leads to a D&X, would that person be liable to prosecution. This is really a legal issue, not a medical issue, but my understanding of the document was that a concept of mens rea held and that was that if the intent of the practitioner was to do a D&E and it evolved into a D&X, that that person would not be culpable.

So I would say that this is again a legal issue, not a medical issue. I am not qualified to comment on it one way or the other. However, I think that that needs to be adjudicated so we have some sense of whether or not that in fact does protect [25] the practitioner because if it does, you know, I don't see the issue here. The vagueness doesn't matter. So that would be one point.

The second issue is how would you make the language less vague. How can you craft an act that prohibits this form of abortion in a way that makes it crystal clear that it's not an alternative form of abortion. I think that's a very hard thing to do. That leads me back to my first point, which is the intent of the practitioner.

* * * * *

[27] continue to agree with that?

A. I am sorry. Maybe you can actually read what we are talking about.

Q. It's in the next paragraph. "First, in my opinion it cannot be applied before viability," which is italicized, "because the "findings," a sort of preamble justification, fail to provide rigorous evidence that the procedure poses greater health risks than alternatives such as D&E, hysterotomy, or induction of labor."

MS. GOWAN: What's the question?

Q. Does that still reflect accurately the Doctor's opinion?

A. I have issues with the findings and the key issues I think are the risk of the procedure vis-a-vis the likelihood of an incompetent cervix. I mean, it's very reasonable to state that there is a positive, not an absence of data that support that position that Congress had and spelled out in their findings that there is some evidence, in fact, reasonably good evidence from both France and Denmark involving very large numbers of patients, over 10,000, in both studies that D&Es increase the risk of preterm delivery in subsequent pregnancies.

Now that observation doesn't prove [28] causality, but it does establish an association between D&Es and the occurrence of preterm deliveries. The D&X procedure, presumably the procedure to be banned in this Act is marked by a greater degree of cervical dilatation than one would, you know, cause to occur with a D&E.

And that would lead one to believe, at least theoretically, that the intact D&X might increase the risk of prematurity compared to a D&E because of the greater degree of cervical dilatation, presumably in-

creased trauma and so forth. However, that's a theoretical argument, and there is a paucity of data to support it.

Chasen's article, that's in press, that I reviewed I guess yesterday, which I didn't mention but now do is clearly inadequate in that there are not nearly enough patients to groups to draw meaningful conclusion. Of concern to me at least was that there was a higher rate of prematurity amongst the group that had had a previous D&X compared to the group that had a previous D&E.

Q. And no statistical—

A. Not at all.

MS. GOWAN: Objection.

A. And inadequate power. Absolutely.

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[30]

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Q. Now, just to go back to your draft of ed piece (Phonétic) which you thought was accurate at the time you wrote it, is it still your opinion that the findings set forth in the act failed to provide rigorous evidence that the procedure poses greater health risks than alternatives?

MS. GOWAN: Objection.

A. Well, I actually spent a good deal of time thinking about this. I think that the answer is that my view of the topic is as follows: That prior to 20 weeks, there seems reasonable evidence that D&Es are associated with fewer complications than medical abortions,

and that after 20 weeks, medical abortions appear to be associated with fewer significant complications than D&Es. There are a couple caveats.

The first is that the complications that are most commonly cited for medical abortions are retained placentas. One could argue that that complication is a less significant complication than the hemorrhages, lacerations and potentially more morbid but rarer complications that occur with a D&E.

So to summarize that statement, they [31] are not the same complications in general. After 20 weeks and particularly with the use of Misoprostol, there is a lower rate of retained placentas. That has to do with the biology of the placenta, and the way it adheres to the uterine wall. As the uterus is larger and the myometrium is thinner, there is an increase risk of perforation with a D&E. So that's sort of a summary of D&E versus medical abortions risks and complications.

D&X is a different procedure than a D&E. Chasen's very small study would suggest that there doesn't seem to be a substantial difference in the rate of complications between D&E and D&X, and so you could probably use the D&X—you could probably use D&E as a surrogate in assessing the safety of a D&X and make the same argument I just made, but again, there is no evidence. There is no good evidence to support the introduction of the procedure, nor is there evidence against its introduction.

Q. Let's go back to the previous paragraph, Doctor. Does it continue to be your view that, quoting the language in the penultimate sentence in the preceding paragraph, "The Act is flawed by its faulty assumptions of the maternal harm that accrue to [32] patients

undergoing a D&X by its vague description of the procedure to be banned."

MS. GOWAN: Objection.

A. I would argue that—well, that I have certainly done more homework than when I prepared this draft in terms of understanding in a far better way the complications of medical abortions and surgical abortions. I think that it's fair to say the converse that it is unclear to me that the D&X offers advantages over medical terminations and D&Es. I guess that would be—I know that's sort of sophistry, but still I think it's valid that, you know, the absence of data doesn't prove the absence of harm. That, in fact, medical abortions, D&Es, and D&Xs are certainly at least comparable, and particularly after 20 weeks, in terms of their safety. So that's a—I realize a very subtle change, but I think it is a different view.

Q. It's subtle enough that it may have escaped me.

This sentence seems to focus upon what you described as the faulty assumptions of maternal harm that accrue to patients undergoing a D&X. That is the faulty assumptions contained in the Act. Is it still your view that the Act's description and [33] findings of the harm—of maternal harms that accrue to patients undergoing a D&X are faulty?

MS. GOWAN: Objection.

A. I believe the findings exaggerate the risk of the procedure.

Q. In terms of the next page, if you would Doctor, the second paragraph of the page says, "Thirdly, the description of the actual procedure being banned is far

too vague and there is no limit on gestational age." Does that sentence continue to be your view?

MS. GOWAN: Objection.

A. Well, there is clearly no limit on gestational age. The issues of vagueness—is the language vague, yes. Does the Act, as constituted, represent a threat to the performance of a D&E? Again, I think this is a legal argument having to do with the intent of the practitioner.

Q. And when you say "vague," the language you used in December was far too vague, is that still—

MS. GOWAN: Objection.

A. Vague.

Q. So your view has changed in that respect?

[34]

A. Again, I am really not trying to mix, and mash, and finesse this. The bottom line is that this is a legal issue to me and not a medical issue. If the law is interpreted in such a way that the intent of the practitioner to perform a D&E is sufficient to render him not culpable to any of these penalties, then it's not vague in that sense. If it's not, then it's not only vague but worse.

Q. The matters that you and I just discussed here were also subjects that you and Ms. Gowan discussed last evening?

MS. GOWAN: Object to the form.

A. Well, I think I made comments. I don't believe she tried to lead me in those comments, if that's what you are eluding to.

Q. When you made comments, did she respond? You had a discussion about this?

A. Yeah, we discussed it, and I said pretty much what I just said.

Q. In what addition or number of Contemporary OB/GYN had you drafted this paper for?

MS. GOWAN: Objection.

A. That's not how it works. I draft lots of editorials. I have a few drafts floating around right now. It's when they actually get published, [35] when I actually send them and say, make this happen. This was certainly, I thought, a great topic for an editorial. I wrote it. I sent it to Sheila saying that I think this accurately reflects my view. I then got a copy of her report to the judge and made sort of the modifications that I just described in my mind at least, concerning vagueness.

Q. So that after you drafted this, you circulated it or you shared it with Ms. Gowan, correct?

MS. GOWAN: Object to the form.

A. I believe I e-mailed it to her. I can't recall exactly how I got it to her.

Q. Did you discuss it with her shortly after you e-mailed it or got it to her.

A. I think that by the time she responded to me, I had actually gotten the additional material that her office had sent me and voiced pretty much the opinion I just voiced, which was that this seemed now to be more of a legal issue than a medical issue. That the wording of the law, the Act was, in my mind, still vague, but that if there was legal—if a legal argument could be made and was bonafide, it's not for me to judge or to even

probably speculate on that anyone with the intent of performing a D&E was [36] protected, if you will, that that would change my opinion about the validity of the act.

Q. You had that discussion with Ms. Gowan after you sent—

A. Way back when, yes. Absolutely.

Q. And is it fair to say that your views, to the extent that they have been modified, have been modified on the basis of what you understand to be legal positions, and facts, and arguments rather than medical facts?

MS. GOWAN: Objection.

A. I have agonized over every aspect of this act and what it means for me, for society, for the country, and agonized is the correct word because it is an incredibly fine line between protecting the life of a potentially viable fetus and respecting a woman's right to choose. Being a maternal field medicine specialist, I think we are at the very front line of that dilemma, and so that is where I tried to sit myself.

Q. Let me ask my question perhaps a slightly different way. The agonizing that you have done, Doctor, has been in the wake of provision of legal argument to you in discussion with lawyers, not on the basis of any newly available medical facts, [37] correct?

MS. GOWAN: Objection.

A. No, both. Legal arguments certainly caught my eye, but I think that honestly the effort I have made to try to discern the relative safety of the three procedures has led me to conclude that they are comparable.

Q. Three procedures being D&E with dismemberment, intact D&E or D&X, and medical abortion or induction?

MS. GOWAN: Objection.

A. (Affirmative nod.) Correct.

* * * * *

MR. HUT: Let me ask the court reporter to mark as Plaintiff's 5 what appear to be three pages of notes.

(Whereupon, the three pages of handwritten notes was marked as Plaintiff's Exhibit 5 for Identification.)

Q. (By Mr. Hut) Doctor, the reason for my * * *.

* * * * *

[54] forces.

Q. You are Board Certified in Obstetrics and Gynecology, correct?

A. Correct.

Q. And likewise in Maternal Fetal Health?

A. Correct.

* * * * *

Q. As chair of the department of Obstetrics and Gynecology at NYU and prefatorily that you were at NYU as Chair how long?

MS. GOWAN: Object to form.

A. 1995 to 2002.

[55]

Q. And in 2002 or 2003, did you move to Yale?

A. 2002.

Q. And you were also, at Yale, Chairman of the Department of Obstetrics and Gynecology, correct?

A. Correct.

Q. As department chair at NYU, did you have responsibilities related to abortion?

A. Yes.

Q. Did you teach others any abortion technique or procedure?

A. No.

Q. Did you supervise abortions?

A. No.

Q. Did you hire physicians who performed abortions?

A. I did.

Q. What were the criteria used to do that?

A. The service was designed to be an academic service that provided training for the residents, clinical service for the patients, and also served as a contraceptive training and research service so that that service was also part of the national institute of child health and development contraceptive work. It would conduct clinical trials [56] in contraceptives. So the person hired had to be able to accomplish all those missions.

Q. How many such physicians did you hire?

A. Two.

Q. Who are they?

A. [REDACTED] who was at Bellevue for I believe a year-and-a-half, two years, and she was replaced by [REDACTED].

Q. Did both [REDACTED] and [REDACTED] perform intact dilation and evacuation procedure?

A. I know that [REDACTED] did.

Q. How about [REDACTED]?

A. I don't recall.

Q. Now, as Chair, you were responsible for what went on in the department, right?

A. Right.

MS. GOWAN: Objection.

Q. You were responsible for making sure that abortions as performed at NYU were safe, correct?

MS. GOWAN: Objection.

A. Correct.

Q. You wouldn't allow an unsafe procedure to be performed in your department, would you?

MS. GOWAN: Objection.

A. Correct.

[57]

Q. You wouldn't allow any innovation in technique that you thought was unsafe, would you?

MS. GOWAN: Objection.

A. Correct.

Q. Are you familiar with the form of abortion procedure called hysterotomy?

A. I am.

Q. You would agree, wouldn't you, that at virtually all stages of gestational age complication rates for hysterotomy are higher than for other forms of abortion, surgical or medical?

MS. GOWAN: Objection.

A. All other things being equal.

* * * * *

[62]

Q. Is it your understanding that no form of a D&E that begins with dismemberment is covered by the Act?

MS. GOWAN: Objection.

Q. Let me withdraw that question and rephrase it.

Is it your position that no form of D&E that begins with the position, either manually or by instrument, grabbing onto a fetal part with the intent of extracting as much of the fetus as possible is covered by the statute?

MS. GOWAN: Objection.

A. So this—we are back to the vagueness argument, and I would say this is a legal argument, not a medical argument. As someone who read the Act and hopefully interprets it in the correct way, it appears to me that the wording is such that the intent of the practitioner should be to deliver the fetus such that a portion of the fetus is outside the vagina, and then conduct some destructive act whether it's the ACOG destructive act or some other destructive act that is intended to kill the fetus and then does kill the fetus. That's how the wording would be interpreted by me.

Q. To your mind, does that include—does [63] that cover a D&E that proceeds by dismemberment?

A. I would hope not.

Q. Does it cover the situation in which the Doctor begins intending to extract a part of the fetus and does not know whether it will proceed by dismemberment or not?

MS. GOWAN: Objection.

A. Well, the wording of the Act doesn't address that. My understanding of the Act is that it has to be the intent—this is the argument that's been forwarded by the Attorney General and his representatives, is that it has to be the intent of the act—of the practitioner to do a partial birth abortion to do precisely what is characterized in the Act's language.

* * * * *

Q. (BY MR. HUT) Dr. Lockwood, could you please return to Plaintiff's Exhibit 5, which is the set of notes that you were helping us out with a moment ago.

The first line says that after 21 weeks D&X is probably safer than D&E?

A. That's what I wrote.

[64]

Q. Do you recall where you obtained that information?

A. This looks like it comes from the ACOG, the Committee opinion, but I am not sure where that comes from.

Q. You are not sure where the line that I just asked you about comes from?

A. Right.

Q. The following four components come from the ACOG Committee statement?

MS. GOWAN: Objection.

A. I don't believe the Committee statement says this. I'd have to actually look at it again.

Q. Do you believe that what you wrote there about the safety comparison between D&X and D&E is correct?

MR. GOWAN: Objection.

A. I believe when I wrote that, I probably thought that.

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[65]

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Q. Do you recall what the basis was for your belief at the time you wrote this statement?

A. Yes, I do actually.

Q. What was that?

A. That D&Es would involve multiple passes of the forceps into the uterus, whereas this procedure would involve hopefully one pass of a forceps.

Q. And that continues to be your belief about the way the procedures or the variations operate?

MS. GOWAN: Objection.

A. That's correct.

Q. When a physician sets out to do any D&Es, isn't it true that he or she intends to make as [66] few passes into the uterus or cervix as possible?

MR. GOWAN: Objection.

A. Correct.

Q. And the reason for that is that the fewer passes the less the risk of—or less the usage of instrumentation, and thus the risk of perforation or laceration, is that true?

MR. GOWAN: Objection.

A. And infection.

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[67]

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Q. If you understood that the person in the Justice Department responsible for enforcement of the ban had testified under oath that there has been no determination as to what procedures are covered and what are not, would that concern you?

MS. GOWAN: Objection.

A. Yes.

Q. If you would turn, Dr. Lockwood, to the third page of your draft statement, there you wrote—and I examined about this paragraph earlier but not about this sentence. The second sentence of the second paragraphs says "Thus, some people may interpret the Act as banning D&Es on 14-week fetuses with lethal anomalies, which places an "undue burden" on women seeking abortion in the second trimester." That accurately stated your view at the time?

MR. GOWAN: Objection.

[68]

A. It still does.

Q. The next paragraph states—actually, could you read that paragraph into the record, Dr. Lockwood?

A. "On a professional note I find distressing"—this was a draft, and I apologize for the grammar—"On a professional note I find distressing is the Act's imposition of criminal penalties on a physician who performs a "partial-birth abortion," further unraveling physicians' social contract with patients. Finally, I think it's entirely unconscionable for Congress to encourage civil suits."

Q. Does that continue to be your view?

A. Absolutely. Particularly the last sentence.

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[73] question, and the answer is that I would differentiate a procedure where the intent was to deliver the fetus intact to the head, puncture the head, aspirate the cerebral contents, and complete the delivery from one where the fetus at 14 weeks was incidentally delivered intact or delivered to the point of the calvarium when it was the intent of the practitioner just to do a D&E. I think that that's a reasonable distinction to make.

Q. How about a gestational age later than 14 weeks? How about at 21 weeks?

MS. GOWAN: Objection.

A. Same.

Q. And so definitionally, you define an intact D&E as distinct from a D&X solely by virtue of what the physician intends to do, correct?

MS. GOWAN: Objection.

A. No. I mean, the procedures do have unique aspects that are not absolutely discriminating but do

define the nature of the procedures being distinct. For example, in an intact D&X, the cervix is dilated to a greater degree than would be necessary for a D&E.

Q. How about for an intact D&E?

MS. GOWAN: How about what? I am * * *.

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[76]

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Q. Let me ask you this: When in your understanding as the procedures were performed at NYU, for example, under your Chairmanship, when does a physician form an intent to do either an intact D&X or dismemberment D&E?

A. Again, this is the basis of my conversations with [**REDACTED**]. Just to put things into perspective, I gave her wide latitude to do the procedure to do D&Es, and to train the residents in doing them.

I recused myself from making decisions at the borderline of viability in favor of an ethics panel at Bellevue. So if someone was 23½ or actually in New York State 25½ weeks, because you could use the point from conception rather than the menstrual date, they would discuss it, and a decision would be made by the panel. She was given wide latitude to makes these decisions.

Frankly, to be really honest with you, [77] my assumption was that she was doing D&Es, and when I talked to her, whenever that was in December or November, she said no, no, no. Because I asked her what she had done the last year. She said no, no, about two

thirds of them were D&Es, but a third of them were D&X. Define D&X. Deliver the fetus to the head, aspirate the calvarium, and deliver the fetus. And how would you decide to do one versus the other? Teaching extended cervical dilatation and so forth.

In her mind, and now I am talking about what was in her mind, there may be some objection that somebody would raise about that. But my sense was that the decision was made most often sort of during the performance of the procedure to reflect the needs to teach and the extent of cervical dilatation.

So she sort of had the option of going either way in some cases. In some cases, obviously, the cervix was very dilated. She might just go ahead and effect the D&X. And in others where it wasn't, even if that were her original intent, she might have done a D&E. Does that address that?

Q. I think it does. The extent of the preparation for both procedures, for either procedure at the same gestational age would be the same, [78] correct?

MS. GOWAN: Objection.

A. They certainly overlap.

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[80] * * * by grabbing another fetal leg with the forceps, and at that time, through the application of traction, extracts the rest of the fetal body to the head, as you understand the act, Doctor, is that covered or not?

MS. GOWAN: Objection.

A. No.

Q. Can you explain in the language of the statute why you think it is not?

MS. GOWAN: Objection.

A. With the caveat that you are now asking me to explain to a lawyer the law. With that having been stated, okay.

So it says "The term 'partial-birth abortion' means an abortion in which the person performing the abortion (A) deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother."

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[81]

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Q. (BY MR. HUT) Accepting the factual predicate that I articulated in the previous question and asking you whether so far in the statute the Act that I described would be covered.

A. No.

MS. GOWAN: Objection. There is no question pending.

MR. HUT: There was a question pending.

Q. Why not?

A. Because it says deliberately and intentionally.

Q. How is it that in the situation that I described, the physician is not deliberately and intentionally, in

the case of a breech presentation, delivering any part of the fetal trunk past the navel to a point outside of the body of the mother?

MS. GOWAN: Objection.

A. Because his intent was to disarticulate the remaining leg, that was his intent, and he was not [82] deliberately trying to deliver the fetus to conform to the rest of the statute.

Q. Do you see any words or language in the statute that would exempt from liability a physician for or in the situation where he or she is deliberately and intentionally wanting to disarticulate a portion of the fetus?

A. Yes.

MS. GOWAN: Objection.

Q. Where do you see that?

A. Deliberately and intentionally.

Q. Deliberately and intentionally delivering a living fetus, right, the Doctor is doing that?

MS. GOWAN: Objection.

A. Right, but that was not either his intent or deliberation. His intent was to disarticulate the leg. He didn't deliberately deliver the fetus at the women's introitus.

Q. I hope I am not appearing to argue with you. That is certainly not my intent, but the deliberateness and intent required is the vaginal delivery of a living fetus in the case of a breech presentation to any part of the fetal trunk past the navel. Nothing about the intent to disarticulate or [83] to dismember, is that fair?

MS. GOWAN: Objection.

A. No, it's not fair. Let me try to rearticulate why it's not fair as opposed to disarticulate. The argument is deliberate and intentional vaginal delivery. When you go to disarticulate a lower extremity and the fetus happens to come out, that's neither deliberate nor intentional.

Q. Is there anywhere in the statute where the deliberation and intent is limited to the extraction of an intact fetus?

MS. GOWAN: Objection.

A. I guess we are looking at the glass as half full and half empty.

Q. Would you agree that it's susceptible to be interpreted either way?

MS. GOWAN: Objection.

A. Well, I think you can look at glasses as half full or half empty. I have no objections to that at all, but I do object to your line of inquiry.

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[84]

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Q. Apart from the Act, as you understand [85] the D&E practice, understood the practice at NYU, didn't all the physicians want to extract as much as possible at one time intact, if at all possible?

MS. GOWAN: Objection.

A. I think that it's fair to respond by saying their eager to minimize the number of passes.

Q. Doesn't that inevitably mean that if they can, they are going to extract it intact if possible?

MS. GOWAN: Objection.

A. Their intent is to make as few numbers of passes as possible, but the presumption—their presumption, their intent is to disarticulate, and very often the head, the calvarium, will stay or some other body part might persist.

Q. Do they care whether they disarticulate or not as long as they extract with the fewest number of passes and intact as possible?

MS. GOWAN: Objection.

A. You are asking me to know their minds.

Q. In effect I am, Doctor, because you are making a fundamental distinction on the basis of what you perceived to be physician intent. So necessarily you, and I, and Judge Casey, Judge Cop (Phonetic), and Judge Hempton [Phonetic] are all going to have to get [86] into this.

Do you think they care about disarticulation or have any intent with respect to this disarticulation as opposed to the evacuation of the uterus with as few passes as possible—

MS. GOWAN: Objection.

Q. —intact, if at all possible?

A. My opinion is they probably don't.

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Q. Let's take a case in which a physician, say at 20 weeks gestational age, believes that he or she is going to perform a D&E by dismemberment, inserts the

forceps through the cervix into the uterus grabs a fetal part, and that fetal part turns out to be a chest or torso, extracts that, you would agree that that is a part of the fetal body past the navel?

MS. GOWAN: Objection.

A. Strictly speaking, yes.

Q. In that instance, the physician would [87] have deliberately and intentionally vaginally delivered such a fetal part?

MS. GOWAN: Objection.

A. If I am reading the Act correctly it says "Deliberately and intentionally vaginally deliver" whatever that means "a living fetus until in the case of a head-first presentation the entire fetal head is outside the body of the mother, or in case of breech presentation, any part of the fetal trunk past the navel outside the body of the mother."

As you are describing a transverse lie, when you remove the thorax, you are doing neither of those things. It's neither a breech presentation or a vertex presentation. You are neither delivering the entire fetus to the point of the navel, nor of the head. You are removing the thorax and removing it from the body.

I am really not trying to be a words smith here, but clearly that's not the intent of the lawmakers in passing this Act. Nor is it the way I, giving great liberty to the English language, would interpret the Act.

Q. Assume something other than a transgress. Assume a breech presentation, but in the process of performing a dismemberment D&E and grasping [88] a fetal part, it happens that the first fetal part extracted

is a thorax, so that that portion of the statute would apply, the breech presentation.

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Q. (By Mr. Hut) Would you tell me whether you think that that situation would be covered by the Act and if not, then why not?

MS. GOWAN: Could you read back Mr. Hut's question, please, and the predicate for it?

(Whereupon, the requested portion of the record was read by the reporter.)

MS. GOWAN: Objection.

A. No.

Q. And why not?

A. Because it was neither deliberate nor intentional. The intent was to grab whatever was there. It turned out to be the thorax. That was removed. It was neither a vaginal nor a vertex or breech delivery.

[89]

Q. Does it make any difference to you whether to extract a fetal head that's accomplished by compression with the forceps or other instrument as opposed to an incision and intracranial suction?

MS. GOWAN: Objection.

Q. When I say does it matter to you—

A. As long as it's not my head.

Q. Does that affect your definition or any distinction you make between an intact D&X and an intact D&E or dismemberment D&E?

MS. GOWAN: Objection.

A. It depends on the context.

Q. Can you elaborate on that?

A. Sure. In the context of this Act, if the intent is to vaginally deliver the fetus as a breech and then to either crush the skull or to aspirate the intracranial contents, that is clearly proscribed by the law. There is no doubt about that. If the intent was to do a D&E, and you happen to grab the calvarium and crushed it, and pulled it out, then that would not have been covered by the Act. So it doesn't matter to me. It only matters to me whether we are talking about the Act or not.

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Q. Other than in connection with your work on this case, you don't regularly review medical literature concerning the provision of abortion, do you?

MS. GOWAN: Objection.

A. Of course I do.

Q. Even before your work on this case began?

[96]

A. I read the literature.

Q. Other than for purposes of this case, what was the last article on the subject of abortion that you read?

A. I've read vast literature on RU486. I suspect I read everything that's ever been published on it. And—

Q. How about with respect to second-trimester abortions? I apologize if I interrupted your answer. Go ahead and finish it.

A. I've read when the articles appear in the Gray or Green Journal or in other publications. I read. I try to at least cover the abstracts of most papers that are presented. As a Chair I need to know the literature.

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[102] with it, so go ahead.

A. You presented two statements. The first was that this might be the only option to save a life and so forth. I would say that I cannot conceive of a circumstance where an intact D&X is the only option for terminating a pregnancy that is pre-viable the state of the fetus or after viability. That there are alternatives including medical abortions and very reasonable alternatives. If there is a circumstance that I can't conceive of where it is, then it should be done, but Potassium Chloride or Digoxin can be administered prior to the procedures.

As far as their statement, I suppose it's possible. I am not omnipotent. I don't know what that potentiality is, but there might be a possible situation where an intact D&X really would be the preferred route, but there are ways in which the practitioner can avoid violating the Act and still carry out the procedure.

Then in terms of the second statement, which is "The potential exist that legislation prohibiting specific medical practices, such as intact D&X, may outlaw techniques that are critical to the lives and health of women."

I would argue that that is not true [103] because, Number 1, there are incredibly few circumstances where this is the only option that's required. That assumes that D&E is available and that no one has, you know, any prohibitions against using it. It's used widely and freely, obviously. If there is a specific circumstance where the procedure, as described in the Act, is required, that it can be preceded by the injection of KCL, Potassium Chloride, or Digoxin and still be done.

You know, I think that the college position is a little different than my position. I think that as a rough rule of thumb, that medicine is best left to doctors to decide.

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[104]

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Q. My question is, with respect to the language that ACOG actually used, which was "The best or most appropriate procedure in a particular circumstance," do you agree that an intact D&X might qualify as such?

MS. GOWAN: Objection.

A. Well, I mean that's their interpretation. I think that my response was—I hope I articulated it—that I really conceive of no circumstance where, particularly after 20 weeks, there is an advantage to D&E versus D&X. There might be an [105] advantage to surgical abortion over medical abortion after 20 weeks in a setting where there was a previous C-Section or other uterine surgery that had been performed. Under those circumstances, rather than subject the woman to a po-

tential risk of Cytotec, or Misoprostol, or other agents that might increase the risk of rupture surgical abortion, is likely to be a better approach.

Is there a slight advantage of D&X over D&E in that context? Frankly, I don't think so, but if there is, and I am missing the boat here, they're some really rare circumstance that I am not privy to that there is the option of using Potassium Chloride or Digoxin, and that neither would present really an undue burden on either the Doctor or the patient to having the procedure done.

Q. With respect to the comparison of D&E versus D&X in that circumstance, you would agree, wouldn't you, Doctor, that with a D&X there would be fewer passes?

MS. GOWAN: Objection.

A. Correct.

Q. And fewer passes would mean less risk of infection, or perforation, or laceration, right?

MS. GOWAN: Objection.

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[106]

A. Correct.

Q. Why wouldn't that constitute an advantage, in that circumstance, of a D&X over a D&E?

A. I think the big issues, the big risks with intact D&X, as defined by ACOG here, for example, are in the internal podalic version, which is potentially a single—although it's a single pass, theoretically it may not be, but presume for a minute that it is, would create greater torsion and greater potential risk of lateral

laceration and of damage to the uterus than multiple passes directly in the center of the uterus where you are not taking a sharp instrument and flipping it laterally to try to affect an internal podalic version. So that has to be weighted against the multiple passes that would be required for a D&E.

I think the second area that is of some concern is in the actual destructive procedure with the calvarium abutting the cervix. It is possible to extend the incision on the calvarium to lacerate the cervix. Is it possible that in trying to collapse the skull you tear the cervix? Either of those things seem to be potential risks. Clearly they are noted in Steve Chasen's preprint. They can occur and apparently with relatively similar frequency to a [107] D&E as a matter of fact. Different sorts of risk are presented by the two procedures.

Q. With respect to D&E versus D&X, in the case of a D&E, there would be greater exposure of the uterus and cervix to sharp fetal fragments, true?

MS. GOWAN: Objection.

A. Correct.

Q. Now with respect to the potential risks from podalic version, I take it that you would not have a problem if the fetus was presenting in breech?

A. Right.

Q. However, if the physician intends to perform a D&X, even with a fetus presenting in breech, that would be banned by the statute, correct?

MS. GOWAN: Objection.

A. Correct.

Q. Dr. Chasen found no greater risk of laceration from podalic version, isn't that right?

MS. GOWAN: Objection.

A. He found no greater risk to the procedure. Is that what you are saying?

Q. That's what I intended to say, and I didn't say that, yes.

A. And that's exactly my point.

Q. So no greater risk between D&X and D&E, [108] even though podalic version may have been performed in the course of—

A. Right, but the preface to this line—

Q. —during the intact D&E?

A. —of inquiry was that the D&X offered select advantages to the D&E. Clearly we can't prove that either based either on publications, more with Steve's article, and although it may be safer, it may not be safer, and I believe most likely it's probably equivalent to a D&E in terms of its overall risks and benefits.

Q. Do you know of any complication in terms of laceration or perforation that you ever heard and ascribed to the performance of a D&X and particularly the podalic version aspect?

A. No.

MS. GOWAN: Objection.

Q. With respect to the destructive procedure that you described, isn't there as much a risk from the collapse of a fetal skull with forceps, in terms of laceration or perforation, as there would be with incision and then suction of intracranial content?

MS. GOWAN: Objection.

A. Well, I think that the risk—the [109] different—I hate to be a word smith, but the difference between the two procedures are that it is the scissors or the scalpel that's opening up the calvarium that presents the risk to that part of the procedure as opposed to catching some of the cervix in the Sopher clamp when you are doing the collapse of the calvarium. So there are sort of different kinds of risks.

Q. And you are not able to say that one is greater than the other, right?

A. Well, they are both sort of similar.

Q. You are not able to say that one occurs with any greater frequency in one procedure versus the other, are you?

A. Where's the data?

Q. Have you ever heard of complication in terms of laceration or perforation as a result of any incision into the skull or the suctioning of intracranial content?

A. Only based on what was written by Steve Chasen.

Q. Does he describe—

A. It doesn't really tell you how the lacerations occurred.

Q. Did you observe in Dr. Chasen's article [110] that the frequency of more severe complications was higher in dismemberment D&E that it was in the intact D&E?

MS. GOWAN: Objection.

A. My recollection now, based on whatever 12 hours of interval, was that they were pretty comparable.

Q. In terms of severity?

A. In terms of risk.

Q. I am trying to—

A. Further complications rates were identical.

Q. I am trying to distinguish, apart from complication rates, a qualitative assessment of the severity of the complications.

MS. GOWAN: Are you making a representation that that information is in the report to the Doctor?

MR. HUT: Absolutely.

MS. GOWAN: I object to the form of the question.

Q. (BY MR. HUT) I am asking the doctor whether he noticed any qualitative difference.

A. I am all over what you are saying. I'd have to the paper in front of me, but if I were [111] reading it, I think there was a more severe complication with a D&E, if I remember correctly, a perforation or something that wasn't present in D&X, but I would have to actually review it. Again, we are talking small numbers.

Q. Do you ascribe any significance to the fact that in Dr. Chasen's study D&X procedures were on average performed at a later gestational age?

MS. GOWAN: Objection.

A. Do I believe that has some kind of import to the performance of the procedure or rationale for the procedure?

Q. Does it have any import with respect to any comparison of the safety between the two procedures?

A. Way too small numbers to really give you a definitive answer, but you presume that it would increase the risk of the intact D&X since the later in gestation you perform any abortion, the higher the risk in terms of surgical abortion.

Q. So the fact that the two turned out in this retrospective study to have comparable complication rates, does that suggest that since the D&X procedures were, on average, performed later that they may in fact be safer?

[112]

MS. GOWAN: Objection.

A. Well, just as you objected to my saying that the preterm delivery rate was higher with D&X with such small numbers, I would say the same, that the numbers are vastly too small to really rule in or rule out any greater or lesser risk to either procedure. They both seem, at least in that small study, to have had comparable risk. If you had a study 10 times that size, you may discern subtle differences in the rate of complication.

Q. I want to get back to observations you had made about the availability of KCL or Digoxin. Are you aware of any studies that show KCL to be safe, when used to effect fetal demise prior to a surgical abortion in the second trimester?

A. Any studies that show that it's safe?

Q. Correct.

A. No.

Q. How about with respect to Digoxin, are you aware of any studies that show that the injection of Digoxin into the amniotic sac prior to a second-trimester surgical abortion is safe?

A. Yes.

Q. What study?

A. Well, there are two studies. I think * * *.

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[125] fair summation.

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A. No. I think what I said or what I meant to say, maybe I didn't say it, was that I can conceive of incredibly a few situations where an intact D&X would be the only procedure that would be required to affect termination of pregnancy. And that in that very rare circumstance, which I can't right now imagine, Potassium Chloride or Digoxin would allow the practitioner to affect an intact D&X without violating the Act.

Q. And is it medically appropriate in your judgment, Doctor, in those few circumstances or incredibly few circumstances, if you posit for the moment that some exist, to require a physician to administer in a patient to receive either KCL or Digoxin in circumstances where the physician believes there is no benefit and some risk to administration of KCL or Digoxin?

MS. GOWAN: Objection.

A. If the physician wants to be in compliance with the law, I see a benefit.

Q. I am talking about a regime in which the law is not in affect prior to the—an enactment of law.

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Q. Have you formed expert opinions with respect to safety based on safety statistics?

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A. Yes.

Q. (BY MR. HUT) And other than reading CDC literature, what would be the basis or what is the basis for the development of those expert opinions?

MS. GOWAN: Objection.

A. Knowledge of maternal fetal medicine, knowledge of fetal development, knowledge of embryology, knowledge of surgical complications of maternal physiology, knowledge of hemostatic systems, for which I think I have some significant expertise, [139] as well as my knowledge of abortion procedures from reading, from lectures, from observations, from GYN, M&M conference, with discussion with the practitioners, and from seeing many complications.

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[140] you have described with perspective directors in the course of your recruitment efforts, have you talked about actual performance of abortion procedures, and safety data, and complications, and whether there are indications that would favor a particular circumstance as one procedure over another?

MS. GOWAN: Objection.

Q. Have you gotten to that level of detail?

MS. GOWAN: Objection.

A. We have talked about the different venues that the procedure could be done in. Should it be done at a women's center? Can it be done in a hospital? Should it be done at the Planned Parenthood? Should we arrange for some kind of joint program? What are the down sides to performing outside of the hospital or the advantages of performing them? What is the environment of New Haven County like for abortion practitioners, and what is the environment of Yale-New Haven Hospital? Is it conducive? Is it supportive? Are there problems? Are there things that need to be covered?

I think that, you know, we certainly tried to identify the strengths and weaknesses of the institution and the area in terms of both early MVAs, [141] medical abortions, D&Es, and although we haven't discussed intact D&Xs, that would be something that I would be willing to discuss, but it's not against the law to discuss it.

Q. Would you expect – do you know whether any of the individuals you have spoken to about assuming the directorship role currently performs intact D&Es?

A. I don't think I have addressed that.

Q. Would you expect to address it if the law were enjoined?

A. I would definitely want to discuss it, yes.

MS. GOWAN: Well, the law has been enjoined.

A. If the law were enforced?

Q. If the law were permanently enjoined.

A. If the law were permanently enjoined, would I discuss it?

Q. Yes.

A. That is an excellent question. One that I haven't thought of before. I think that the answer to the question, honestly, is no. I would leave it up to the provider, as long as I was confident in their competence and their ability to * * *.

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Q. And would have no objection to such a person performing or teaching intact D&E, assuming that it were lawful to do so?

MS. GOWAN: Objection.

A. My role is to ensure that we are in compliance with the RRC's requirements to provide access to abortion training for our residents. One is to protect the health of our patients. Two, to make sure that the training is available, and three, do that in the context of an academic center means to conduct research and so forth. I'd expect all three of those things to be the keys to my decision. If intact D&Xs are being used, so be it.

I think that the same—I would apply the same rules and criteria for having decisions made about terminations after 20 weeks here that we did at NYU, which is to leave it up to the threshold of viability, leave it up to a panel and recuse myself from any of those individual decisions that would have to be made.

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[154]

On the other hand, the issue—the counterbalancing issue—this is all speaking to moral ambiguity is the issue of protecting a woman's right to choose and being in compliance with previous Supreme Court rulings, and that sort of has two aspects. Is this procedure less safe as some have alleged than the other two procedures, and I don't think it is. It's pretty clear. Is it more safe? I don't think it is either. I don't think that it's either less or more safe than a D&E, and after 20 weeks, I suspect medical termination is safer than both.

So that if one argues that depriving women of the availability of this procedure would prevent the ability to have a termination, I don't agree. And as to its benefits in certain health circumstances, I don't agree with most of the comments made by the experts for the plaintiffs.

However, there may be circumstances, rare, that haven't considered where a D&X is required to protect the health and safety of the mother specifically, and if that's the case, then I would contend the availability of KCL and Digoxin to allow one to still perform the procedure. That's a very long winded response, and I apologize. I think it [155] summarizes my thinking about the case.

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Q. Do you favor the right to have a termination via an intact D&X if that is the best procedure in the judgment of her Doctor and herself?

MS. GOWAN: Objection.

A. I believe that we should be aware that fetuses, particularly after 16 weeks and certainly [156] after 20 weeks, do have neurological function, can respond to pain, and that we should favor those procedures which minimize pain and permit full access of a women to make a decision about continuing her pregnancy.

So that what I guess I am saying or trying to say is independent of this act. I think that it behooves all practitioners to be as humane as they can, be cognizant that fetuses do feel pain, and the procedure that they choose ought to be chosen in a way to minimize that pain. Whether that means KCL or Digoxin for all, frankly, yes, I would favor that. Absolutely. Certainly after 16 weeks.

On the other hand, am I prepared to say that that's mandatory, no, because I think that the Supreme Court is correct and that the State shouldn't provide undue burden to access the procedure to abortions. But my personal preference is to minimize the pain and suffering of a fetus, certainly after 16 weeks and absolutely after 20 weeks.

Q. With respect to that question, Doctor, in the course of any D&E or intact D&X procedure that you have observed, have you seen any demonstration of fetal sensation to pain following the administration of the anesthesia?

[157]

MS. GOWAN: Can we have the question read back, please?

(Whereupon, the requested portion of the record was read by the reporter.)

MS. GOWAN: Objection to form and lack of foundation.

A. Number 1, I have never seen a D&X so, I can't comment. Number 2, it would be very hard to discern the response in terms of pain in a D&E if you are not doing an ultrasound to do it. Number 3, when you do an ultrasound, and I have and observed this certainly the fetus responds in a violent way to disarticulation and dismemberment. I think that the very elegant discussion of fetal neurodevelopment and the pathways and response to pain, as well as its ability and visual evoked responses, and now pet imaging, and through, you know, an analysis of neural anatomic pathways would strongly suggest that fetuses before 23 weeks and, in fact, sometime after 16 weeks do in fact feel pain, and after 20 weeks are likely to process the information in a way that we would view as sentient [Phonetic].

Q. You don't think there is any basis to you to distinguish whatever pain or sensation the * * *.

* * * * *

[162] exception to preserve the life of a mother with an exception to preserve the health of a mother?

MS. GOWAN: Objection.

A. Again, let me reiterate it for the sixth time. I don't perceive any condition where the health of the mother is better served by D&X versus D&E versus a medical abortion. There might be circumstances, however, and I have eluded to the possibility of having a previous uterine scar being one where particularly procedures done after 20 weeks are better done surgically than medically, but I don't see any necessary advantage. At this point there is no evidence in the

literature of this that the D&X would offer any specific advantages over a D&E.

However, as I said 15 times, there may be a circumstance, which I am unaware of, and in those circumstances, that treatment of KCL of Digoxin would allow one to do it and not violate the law.

Q. I completely understand that response, but let me ask you this: The act contains no exception where the procedure may be necessary to preserve the health of the women, correct?

MS. GOWAN: Objection.

A. Well, the wording is such that it could be interpreted as either health or life. And—

[163]

Q. What wording is that, Doctor?

A. This is S7(a). It says that—where does it say it? Maybe it's not here.

Q. It's actually in Subsection A as Ms. Sternberger reminds me.

A. "Any physician who, in or affecting interstate or foreign commerce, knowingly performs a partial-birth abortion and thereby kills a human fetus shall be fined under title or imprisoned not more than 2 years, or both. This subsection does not apply to partial-birth abortion that is necessary to save the life of a mother whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself." Clearly, any condition which endangers life would endanger health. I am sophistry. I admit it. The argument is that anything that endangers

life would also endanger health. So in that sense—in that narrow sense, it also protects the health of the mother.

Q. And if the statute did not contain the exception that you just eluded to, which you say in that sense exempts the procedure, if necessary, to save the health of the mother, would you believe it to [164] be appropriate in your medical judgment?

MS. GOWAN: Objection. You just asked the witness if a law was appropriate in his medical sense?

MR. HUT: Right. I want the answer.

MS. GOWAN: Objection.

A. So this is obviously an enormous issue, and one that we eluded to at the very beginning of this deposition, and that is how severe does a health problem have to be do justify the availability of abortion. Obviously it pertains more acutely to events that occur after viability. I would argue that there aren't any. Period. There is no circumstances where the life of the fetus needs to be forfeited to protect the mother's life. Period. End of discussion.

Prior to viability, any act, medical abortion, D&E, D&C, hysterotomy, you name it, any act affects termination of pregnancy by definition will result in the death of the fetus. So the issue then is the health of the mother endangered by the lack of availability of this procedure. I would answer to that by saying no. (A) because you still have medical termination which probably are safer after 20 weeks. (B) you still have D&Es prior [165] to 20 weeks, and (C) you can still do the procedure described in this Act, but you need to first treat the fetus with Potassium Chloride or Digoxin. I think I am answering your question.

Q. Let me just ask a couple of follow ups to make sure you are.

Despite the availability of hysterotomy, medical abortion, dismemberment D&E, is it your position that it is important that the statute contain an exception where a D&X intact is necessary to save the life of the mother?

MS. GOWAN: Objection.

A. It may seem that to say it doesn't need to have an exception for health and does need to have an exception for life is illogical, but I would say that when one is dealing with the health, there is less urgency than with life. If a patient's life is endangered, whatever the doctor thinks would work, great, do it. That's the top priority.

When a patient's health is endangered, I wouldn't say there is a luxury of time, but there is obviously more time available to consider other options, which would include medical termination, D&E, or using KCL or Digoxin.

There is an urgency that envelops [166] conditions where the life of the mother is at stake which don't exist where the health of the mother is at stake.

If someone has a medical condition, let's say cancer, where the termination of the pregnancy would allow chemotherapy and radiation therapy and so forth, then the delivery should be expedited, but does it matter which of those three techniques are available, no, not really.

If the mother is bleeding to death and she needs to be delivered immediately and the doctor only knows how to do an intact D&X, that's it. That's his whole

repertoire, well, in fact you are still not going to do it in that circumstance because she needs to be delivered by section, by hysterotomy, or what have you. She's bleeding to death, but if there is something in between those two extremes where the life of the mother is endangered and she can still wait three days to have the intact D&X, then I think it's reasonable that the law protect the practitioner and allow her to do that.

But you know reality, is there any circumstance where really the life of a woman would only be saved by waiting three days and doing a intact D&X as opposed to a D&E or medical abortion that could [167] be done potentially sooner, or quicker, or a hysterotomy. In all likelihood there is not, but what I am saying is give the benefit of the doubt to the mom. Don't preclude any procedure if her life is in danger and allow the physician to do that.

Q. But you would not give the same benefit of the doubt to the mother in the case of a condition that would permanently compromise her health?

MS. GOWAN: Objection.

A. Not as long as there are alternatives that would protect her health in exactly the same way—just as well and that are arguably less cruel or gruesome to the fetus. If that's not the case, then absolutely I would concur with you.

Q. In that life threatening circumstance, there is still the availability without compromising the speed of the procedure, in your judgment, to inject KCL or Digoxin, correct?

A. You are waiting two or three days for the Laminaria to cause cervical dilation, so you clearly have the luxury of time. Yes.

Q. Withstanding that availability, you would not require the Doctor in the circumstance where the condition affects or threatens to affect maternal life to administer KCL or Digoxin, correct?

* * * * *

[185]

* * * * *

Q. And I take it that you would agree that D&Es are performed in different ways by different doctors?

A. Correct.

Q. The steps that you outline on page 6, [186] 7, and 8 are not how every Doctor does D&E, right?

A. Correct.

Q. Doctors will vary the procedure in small ways, depending on the patient, depending on their own skill set, correct?

MS. GOWAN: Objection.

A. And training.

Q. But with your emendation, my statement is correct?

A. Correct.

Q. And I take it you would agree that physicians should not all be required to use the same exact technique for every D&E?

A. Correct.

* * * * *

[193]

* * * * *

Q. But you would have no objection, would you, to the inauguration of a longer period of dilation based on the intuitive judgments about its logical safety advantages?

MS. GOWAN: Objection.

A. Well, I never like support any intervention that hasn't been subjective to rigorous or at least some clinical evidence. It doesn't necessarily have to be randomized clinical trial. It can be retrospective in nature. There are such studies to support this verse Laminaria and do support it.

I think that what you are asking is * * *.

* * * * *

[197] doing a randomized clinical trial of D&Es at 18 weeks with or without Laminaria, no it's not, but there is certainly evidence, both sorts of crude evident and logical data given and other bodies of data that this a very reasonable, safe and reasonable approach to doing the procedure.

Q. How do you draw the line there, Doctor, between an innovation that would, in your judgment, benefit from initially a retrospective study and then perhaps some sort of more randomized controlled study versus a variation in an already established procedure, perhaps in a minor variation?

MS. GOWAN: Objection.

A. You know, it's really an important question because we grapple with it all the time. It's a continuum of innovation and some very minor. Like today, for example, we did a C-Section, and we just slightly modified the way we closed the uterus. I don't plan to

do that again, but it could be construed as a surgical innovation spurred on by the circumstances of that particular case.

At some point the modification of an established technique exceeds that sort of relatively trivial change and becomes an entirely new approach, and when that happens, I think you are obligated to * * *.

* * * * *

[208]

Q. If you understood or if you learned that providers of mid second-trimester surgical abortions dilate the cervix to the same extent for dismemberment D&E as they do for an intact D&X, would that affect your view as to the relevant safety of the two procedures?

A. Well, firstly I think they often do. I gave you the example of Bellevue. Two, I think that the procedures are very likely to be comparable. I think I have stated 17 times that I know of no evidence that an intact D&X is more dangerous than a D&E.

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[218]

* * * * *

Q. Can inductions be performed before 15 weeks?

A. Theoretically it can be performed I wouldn't recommend it.

Q. Retained placenta is a potential complication of induction?

A. It's a complication.

Q. And your report indicates that there is a 10 to 30 percent chance of retained placenta?

A. Correct.

Q. Inductions sometimes fail?

A. Correct.

Q. What do you do if they do fail?

A. Depends on the circumstances. So one [219] option is continue, if there is no pressing need to move to another procedure and the alternative is to have the patient have a D&E.

* * * * *

Q. And you contemplate the possibility that if the director who you are seeking to hire wishes to do so, that they would be taught at Yale, correct?

[220]

MS. GOWAN: Objection.

A. Yes, if it's legal.

Q. In performing a previability induction, does it ever happen that the fetus is partly expelled in breech presentation, but before the head is delivered, the woman becomes infected or sustains excess bleeding and the procedure must be completed with instruments?

A. Though it would be very unlikely that in a very rapid period that the head was retaining the calvarium and that the woman would become infected, but it's an unlikely scenario. The bleeding, however, could occur.

Q. And in the event that bleeding occurred and the procedure was completed with instruments, would one of the options available to the physician be to compress the fetal skull with forceps and facilitate the completion of the delivery?

A. Correct.

Q. The fetus could have indications of life while this occurred before the compression occurred?

A. Correct.

Q. And when a physician begins an induction, and the circumstances that I identified [221] occurred he doesn't know at the outset—sorry withdrawn.

When a physician begins an induction the physician may know at the outset that circumstances may occur and would necessitate the instrumental completion that you have just described, correct?

MS. GOWAN: Objection.

A. Correct.

* * * * *

[230]

* * * * *

Q. So as between dismemberment D&E and an intact D&X, one cannot conclude that there is any greater risk of AFE in respect to either procedure, can you?

A. Correct.

* * * * *

[232]

* * * * *

Q. Do the documented risks of conversion relate to periods closer to term when the uterine wall is thinner?

MS. GOWAN: Objection.

A. Of internal podalic version?

Q. Correct.

A. Yes.

Q. And the risks incident to internal podalic version are lower when ultrasound is available?

A. You would assume so.

[233]

Q. Doesn't your report make the same assumption?

A. Absolutely.

* * * * *

[235]

* * * * *

Q. Doctor, when a physician performs a D&E contemplating that it is going to be a dismemberment D&E and has not done anything intentionally or especially to achieve an intact delivery, does the physician in that circumstance know that he or she may achieve a delivery of an intact living fetus up to the head?

MS. GOWAN: Objection.

A. I think they would now.

Q. And would they before?

MS. GOWAN: Objection.

A. I think the key question is did they deliberately and intentionally do the procedure with that intent in mind or were they planning to do a D&E and it became an intact D&X.

Q. I am attempting now to focus not on the words deliberates intent but on the physicians' knowledge. Would the physician in that circumstance know that he

or she might achieve delivery of an intact fetus up to the head?

A. I think that anyone with the skill to do the procedure and sufficient experience knows that that is a possibility.

Q. And in that situation, the physician [236] would also anticipate that he or she might have to perform an action that results in fetal demise, right?

MS. GOWAN: Objection.

A. Correct.

Q. And to vary the question only slightly, at the outset of a dismemberment D&E, without having done anything special or intending to achieve an intact delivery, a physician may know that he or she may achieve delivery of a mostly intact living fetus, correct?

MS. GOWAN: Objection.

A. Certainly if the first point was true, then the second point is even more true.

Q. In that circumstance would have to or would anticipate having to perform an action that results in fetal death, correct?

MS. GOWAN: Objection.

A. True.

* * * * *

[237]

A. Well, there clearly would never be a condition where a medical termination wouldn't accomplish the same thing as a D&X. And there are many conditions where a D&E in publications, in fact, would achieve the same diagnostic value as a medical termination. There-

fore, I honestly can't think of a circumstance where it would be the only method that would allow one to produce an adequate pathological specimen.

Q. What about the following circumstances: An induction is contraindicated for the woman in question. The abnormality in question is not chromosomal, but it is in fact structural. In that circumstance, would it not be desirable and sometimes necessary to achieve as intact a fetus for diagnostic purposes as possible?

MS. GOWAN: Objection.

A. It would depend on whether or not the intracranial contents were a key part of that evaluation. Very many genetic syndromes involve abnormalities of the central nervous system. It didn't really matter whether you did a D&X or a D&E under those circumstances. You are not going to get good data in either case. If it were some limited circumstance where the pathology were confined to the [238] intraabdominal cavity, then it might be a better way to go than to do a D&E, but probably marginally beneficial. The key piece of information for many diagnoses are the intracranial contents, which need to be prepared in the correct way and so forth. Medical abortion would probably be a better way to do it. When I really am puzzled by a diagnosis I incur strongly encourage patients to opt for medical termination under those circumstances.

* * * * *

[241]

Q. And at what point would cephalocentesis be performed?

A. It can be performed prior to the procedure being done, through amniocentesis. It can be performed

during the procedure when the head, if the head were in the vertex presentation, the contents could be aspirated, and/or it could be accomplished after giving Potassium Chloride and delivering the fetus to the head and aspirating the contents that way.

Q. If the head were lodged in the cervix during the procedure and cephalocentesis performed, that procedure would result in fetal demise, would it not?

A. Not in all. Not necessarily and certainly wouldn't have to be the intent of the practitioner to have that be achieved because aspiration of the cervixonal fluid would cause the head to contract. That was how we delivered viable pregnancies. I recall that even as a young fellow here that that would be the method of delivering these babies not intending in fact that they were to die.

* * * * *

[PLAINTIFFS' EXHIBIT 6]

23 completed week gestation when the life of the fetus must be forfeit to preserve either the health of life of the mother. Thus, the State's obligation to protect the potentiality of life must be given full consideration after this point. Currently, a fetus born at 23 completed menstrual weeks following preterm labor could be aggressively treated and salvaged, while, in the next room, a patient has chosen to terminate a fetus at the same stage of development based on her personal choice. I do not believe that we can, as a society, justify spending billions of dollars to treat very premature infants desperately desired by their parents, while permitting the termination of similarly aged healthy fetuses. We must in some reasonable way balance the rights of a woman and the rights of babies, and draw a line on this slippery slope where there is a collision of two great forces—the right to choose and the right to life—both of which I support.

/s/ CHARLES J. LOCKWOOD, MD
CHARLES J. LOCKWOOD, MD

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

No. 03 Civ. 8695

NATIONAL ABORTION FEDERATION, PLAINTIFFS

v.

JOHN ASHCROFT, IN HIS CAPACITY AS
ATTORNEY GENERAL OF THE UNITED STATES,
DEFENDANT

DEPOSITION OF WAN J. KIM

Friday, Feb. 13, 2004

APPEARANCES:

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[6]

* * * * *

WAN J. KIM, Main Justice Building, 950 Pennsylvania Avenue, Northwest, Washington, D.C., called for examination by counsel for Plaintiffs and having been duly sworn by the Notary Public, was examined and testified as follows:

[WIGMORE EXAMINES KIM]

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[15]

* * * * *

Q. Are you currently employed by the United States Department of Justice?

A. Yes.

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[16]

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Q. And what position do you currently hold?

A. I am currently the Deputy Assistant Attorney General in charge of criminal, housing, [17] civil enforcement and education matters.

* * * * *

[18]

* * * * *

Q. Are you part of a particular division of the Department of Justice?

A. Yes.

Q. What division?

A. The Civil Rights Division.

Q. What does that division do?

A. We enforce a number of statutes that in the main deal with instances of discrimination.

Q. Is your position that you currently hold a political appointment?

A. Yes.

Q. And did you receive that political appointment in 2003?

A. Yes.

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[20]

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Q. Do your responsibilities include criminal enforcement?

A. Yes.

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[24]

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Q. In your current position as the Deputy Assistant Attorney General, do you have any responsibility for implementing or enforcing the Partial-Birth Abortion Ban Act of 2003?

A. It's hard for me to respond to the question because I think it's—let me see if this is an answer, and then obviously you'll follow up. The Civil Rights Division is charged with the enforcement of the Partial-Birth Abortion Ban Act. There has been no imple-

mentation or enforcement as of this date based upon the orders issued by the three courts.

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[40]

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Q. Is there any Department of Justice policy or guidance or blue sheet on how the act will be enforced in the event that an injunction is no longer in force in one or more of the lawsuits challenging the act's constitutionality?

A. Are you asking me if there's a specific document that addresses the question of what we would do once the injunction—if the injunction is removed?

Q. That's correct.

A. No.

Q. And I want to change the question slightly and not reference a document, but whether there's just a policy, whether written or unwritten, as to how the Department of Justice will enforce the act in the event there's no longer an injunction.

[41]

A. No.

* * * * *

Q. And you are the person who's been identified in the interrogatories as the individual who has knowledge or information about the enforcement of the act, correct?

A. I am.

* * * * *

Q. Has the Department of Justice made any determination regarding what type of procedure or procedures will be subject to enforcement under the act?

A. Again, I don't sit here today as a representative of the Department of Justice. I [42] myself am not aware of such a decision.

Q. And again, you are identified as the person in the Department of Justice who has knowledge about enforcement; is that correct?

A. I am.

* * * * *

[65]

* * * * *

Q. Sure. To your knowledge, does the Department of Justice have any final policy on whether the act will be enforced against procedures performed on fetuses that are not viable?

MR. HENRY: Same objection.

A. To my knowledge, I'm not aware of any final policy decision regarding how the act would be enforced. * * *.

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[68]

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Q. Is one of the issues that you have not yet tackled the scope of the procedures that will be subject to enforcement?

A. Oh, you're talking about the actual procedures by the physicians that are covered by the act?

Q. Yes.

A. Absolutely.

* * * * *

[94]

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Q. Has the Department of Justice reached any final policy decision as to whether a physician must deliver the fetus intact in order to violate the act?

MR. HENRY: Objection, vague, asked and answered.

A. I am not aware of any such policy decision, final policy decision.

* * * * *

[101]

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Q. Has DOJ reached a final decision or policy as to whether in cases in which a physician performs a partial-birth abortion as defined by the statute but could have saved the patient's life had he performed a hysterectomy, whether that would be a violation of the act?

A. DOJ has reached no final decision regarding any of the circumstances beyond what you see in the field guidance itself as far as I'm [102] aware.

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[115]

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Q. Has DOJ reached a policy decision as to whether the act bans only late-term abortion procedures?

MR. HENRY: Same objection as before. You can answer the question with respect to final Department of Justice policies.

A. As I've testified earlier, I am not aware of a final policy decision regarding terms beyond what was declared in the field guidance issued on November 5th.

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[116]

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Q. Has the Department of Justice reached any final policy decision as to whether the act applies to only one method of abortion?

[117]

MR. HENRY: Object to form.

A. I'm not aware of one.

* * * * *

[122]

[EVANS EXAMINES KIM]

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Q. For the purposes of my questioning, gestational age means how far along the pregnancy is. Has the Department of Justice made any final policy decisions about whether or not the act will apply before a fetus is viable?

MR. HENRY: Object as to form.

A. I'm not aware of any.

Q. And has the Department of Justice made any final policy decisions about how early in the pergnancy the act will apply?

MR. HENRY: Object to form.

A. I'm not aware of any.

* * * * *

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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03 Civ. 8695(RCC)

NATIONAL ABORTION FEDERATION, ET AL.,
PLAINTIFFS,

against

JOHN ASCHROFT, IN HIS CAPACITY AS ATTORNEY
GENERAL OF THE UNITED STATES, DEFENDANT

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

Civil Action No. 4:03CV385

LEROY CARHART, M.D., WILLIAM G.,
FITZHUGH, M.D., WILLIAM H. KNORR, M.D.,
AND JILL L. VIBHAKAR, M.D., ON BEHALF
OF THEMSELVES AND THE PATIENTS THEY SERVE,
PLAINTIFFS

v.

JOHN ASCHROFT, IN HIS CAPACITY AS
ATTORNEY GENERAL OF THE UNITED STATES,
AND HIS EMPLOYEES, AGENTS AND SUCCESSORS IN
OFFICE, DEFENDANTS

UNITED STATES DISTRICT COURT FOR THE
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

No.: C 03 4872 PJH

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. AND PLANNED PARENTHOOD GOLDEN GATE, PLAINTIFFS

v.

JOHN ASCHROFT, ATTORNEY GENERAL OF THE UNITED STATES, IN HIS OFFICIAL CAPACITY, DEFENDANT

DEPOSITION OF
WILLIAM MOSCHELLA
Feb. 25, 2004

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AND

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ALSO PRESENT:

DONNA LEE, ESQUIRE, PLANNED PARENTHOOD

* * * * *

[WILLIAM E. MOSCHELLA—DIRECT EXAMINATION]

[8]

* * * * *

Q. Could you please state and spell your name for the record.

A. Sure. William, W-I-L-L-I-A-M, Emil, [9] E-M-I-L, Moschella, M-O-S-C-H-E-L-L-A.

Q. Would you please provide your business address?

A. Sure. 950 Pennsylvania Avenue, Northwest, Washington, D.C., 20530.

* * * * *

[11]

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Q. How did you become familiar with that statute?

A. Well, I became familiar with it because before I worked at the Department of Justice, I worked on the House Judiciary Committee.

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Q. Did you hold more than one position during the time you spent at the House Judiciary Committee?

A. Yes. The first stint I was just a counsel to the Committee. In the second stint, I worked for two different chairmen, and one as the Chief Oversight Counsel, and then one as the Chief Legislative Counsel and Parliamentarian.

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[66]

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Q. What did Bill Wichterman and Peter Coniglio discuss during their conversation, to the extent you know?

A. Scheduling, Senate scheduling of the conference report on this Act, this bill, I should say, S.3.

Q. Okay. Now, I want to turn to—I'm just going to read the first two sentences of the next paragraph so we have context. It says, "He said that Douglas Johnson of National Right to Life asked that the Senate not rush to conference on the PBA [67] bill. He believes that there is an advantage to waiting to see if a vacancy occurs on the SC, and then go to conference on PBA in conjunction with the vacancy." Did I read that correctly?

A. You did.

Q. And is it true that National Right to Life was recommending delaying finalization of the partial-birth abortion legislation in the hopes that a vacancy would emerge on the Supreme Court?

MR. BOYLE: Objection, form and foundation.

A. I really can't speak to that. I only know what's on this page.

Q. That's what Mr. Coniglio was reporting to you; correct?

MR. BOYLE: Objection, form.

A. He was reporting what this third sentence says.

Q. And the initials "SC" in that second sentence of the second paragraph, did you understand that to refer to the Supreme Court?

A. I did.

Q. The next sentence of the same paragraph reads, and this is the last sentence of the paragraph, "Johnson believes that the PR would be [68] advantageous to our side to wait and see if a vacancy occurs before going to conference on PBA, and Frist's office is inclined to go along with this strategy." Did I get that right?

MR. BOYLE: Did you read that right?

MS. WIGMORE: Yes.

A. I think it's an "of" instead of an "if" but otherwise you have read it correctly.

Q. And Mr. Coniglio was reporting to you that Frist's office was inclined to go along with the strategy recommended by Doug Johnson. Is that correct?

MR. BOYLE: Objection to form.

A. That's what he seems to be reporting.

Q. Do you have any reason to doubt the accuracy of that report?

MR. BOYLE: Objection to form.

A. No.

* * * * *

[69]

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Q. Just referring you to the third line from the bottom of this e-mail, which reads, "For what it is worth, Bill W. said that Hatch is okay with this [70] too." Did I read that correctly?

A. Yes.

Q. Who does "Hatch" refer to there?

MR. BOYLE: What did he understand Hatch to mean?

A. I understood it to be a reference to Senator Hatch.

* * * * *

[Pl. Exh. No. 19]

[1]

Dilation and evacuation at ≥20 weeks: Comparison of Operative techniques

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[2]

In patients undergoing surgical abortion at ≥ 20 weeks, dilation and evacuation and intact dilation and extraction result in similar complication rates.

[3]

Objective: The objective of this study is to compare the relative safety of two techniques for surgical abortion late in the second trimester.

Study Design: Retrospective review of patients who underwent surgical abortion at ≥20 weeks' gestation at our hospital from 6/1996-6/2003. Records were reviewed to determine if the technique used was dilation and evacuation or intact dilation and extraction. Subsequent pregnancies at our hospital were identified, and obstetric outcomes were recorded. Categorical data were compared with Fisher's exact test and Chi-square analysis. Continuous data were compared with Mann-Whitney U test.

Results: 383 patients met inclusion criteria. Intact dilation and extraction was performed in 120 cases, and dilation and evacuation was used in 263. Intact dilation and extraction was associated with higher parity, later gestational age, and more preoperative cervical dilation. There was no difference in procedure time or estimated blood loss in the two groups. Complications occurred in 19 cases (5.0%), and occurred with similar frequency in the two groups. We identified 62 subsequent pregnancies. There were no second-trimester miscarriages. Spontaneous preterm birth occurred in 2 of 17 (11.8%) pregnancies in the intact dilation and extraction group, compared to 2 of 45 (4.4%) in the dilation and evacuation group (p=0.30).

Conclusion: Outcomes appear similar between patients undergoing dilation and evacuation and intact dilation and extraction after 20 weeks' gestation. Subsequent obstetric outcomes are similar between the two groups. The technique for surgical abortion should be determined by the physician based on intraoperative factors.

Key Words: Abortion, Dilation and evacuation

[4]

In the United States, induced abortion late in the second trimester is uncommon. In 1999, 9,643 abortions were performed at ≥21 weeks' gestation, representing only 1.5% of total abortions reported.[1] Dilation and evacuation is the most common method used for second trimester abortion,[1] and is considered the safest abortion technique in the second trimester.[2-5]

Dilation and evacuation involves preoperative dilation of the cervix using osmotic dilators, such as laminaria, which are placed in the cervix for one or more days prior to operative evacuation. All published reports of dilation and evacuation have described the use of grasping forceps to remove the fetus and placenta. Using forceps, fetal parts are grasped, and the fetus and placenta are disarticulated as they are removed. Low complication rates for this procedure have been reported.[2-5]

A variant of dilation and evacuation can be performed when sufficient cervical dilation is present. In these cases, the fetus is delivered via breech extraction. If the fetus is not in the breech presentation, internal podalic version may be performed. In most cases, after delivery of the body, the fetal head will become lodged in the cervix, and cranial decompression with suction must be performed to complete delivery. This

procedure has been referred to as intact dilation and extraction, or D&X. There is no published data regarding the frequency or complication rate of this procedure. Despite this, some have stated that this procedure poses serious maternal risks and is less safe than dilation and evacuation.[6,7]

The objective of this study is to evaluate the relative safety of dilation and evacuation and intact dilation and extraction in patients undergoing surgical abortion late in the second trimester.

[5]

Materials and Methods

This study was a review of patients who underwent surgical abortion at ≥20 weeks' gestation at the New York Weill Cornell Medical Center from June 1996 to June 2003. All procedures included in this study were performed by one of two physicians (STC and WKR) who are skilled in both techniques, dilation and evacuation and intact dilation and extraction. Institutional Review Board approval was obtained for this study.

Gestational age was confirmed by ultrasound in all cases. All cases ≥24 weeks' gestation were performed due to fetal demise. Dilation of the cervix was achieved with insertion of laminaria. Laminaria were placed preoperatively on two consecutive days, unless the cervix was sufficiently dilated at the initial examination. Women who went into labor following laminaria placement and delivered without dilation and evacuation of intact dilation and extraction were not included in this study.

The surgical technique was determined when the patient was examined under anesthesia, and was based on cervical dilation and fetal position. Both physicians

performing these procedures used similar criteria in determining the optimal surgical technique. All cases were considered complete when, after evacuation of the fetus and placenta, hemostasis was apparent after sharp and suction curettage. Blood loss was estimated by the surgeon. Procedures were performed in an ambulatory setting, unless patients had been hospitalized prior to the procedure for medical or obstetric conditions. The type of anesthesia used for the procedure, general, regional, or intravenous sedation, was at the discretion of the anesthesiologist. Intraoperative ultrasound guidance was not routinely used.

Operative reports were reviewed to determine the technique used in each case. If the fetus was delivered intact in the breech presentation to the level of the umbilicus or higher, the [6] procedure was considered an intact dilation and extraction, whether or not the entire fetus was removed intact or decompression of the head was required. In some cases, the presenting fetal head was well applied to the cervix, and was initially decompressed with suction, followed by intact delivery of the fetus. These cases were also considered intact dilation and extractions, as disarticulation with forceps was not required. All other cases, which were performed with multiple insertions of forceps, were categorized as dilation and evacuation.

Complications included any situation requiring unplanned intervention. These included unplanned hospital admission, repair of any genital tract lacerations, return to the operating room for additional procedures, and blood transfusion. Subsequent pregnancies at our hospital were identified from review of medical records. We did not obtain follow-up on patients routinely, so subsequent pregnancies with prenatal care obtained

elsewhere were not included in this analysis. 38 patients in this series, 26 of whom underwent dilation and evacuation and 12 of whom underwent intact dilation and extraction, were included in a prior publication describing obstetric outcome after second trimester abortion.[8]

Demographic characteristics and outcomes were compared based on operative technique. Categorical variables were analyzed using two-tailed Fisher's exact test and Chi-square analysis where appropriate. Mann-Whitney U test were used to analyze continuous variables, which were not normally distributed. Analysis was done using SPSS 11.0 (Chicago, Ill). A p value <0.05 was considered significant.

Results

383 patients met inclusion criteria. Intact dilation and extraction was performed in 120 cases (31.3%), and dilation and evacuation was used in 263 (68.7%). Demographic [7] characteristics of the two groups are listed in Table I. Intact dilation and extraction was associated with later gestational age, higher parity, and younger maternal age.

Indications for surgical abortion are listed in Table II. Preterm cervical dilation and/or preterm premature rupture of membranes (PPROM) were more common in those who underwent intact dilation and extraction. Abnormal fetal karyotype was more common in those who underwent dilation and evacuation.

Intraoperative variables are listed in Table III. Overall, laminaria were used in 96.1% of cases. Laminaria were less likely to be used in patients undergoing intact dilation and extraction. All 15 patients in whom laminaria were not used had preterm cervical dilation.

Preoperative cervical dilation was greater in those who underwent intact dilation and extraction. No differences were noted in procedure time or estimated blood loss between the two groups.

In the entire group of 383 patients, complications occurred in 19 cases (5.0%). Complications occurred with similar frequency in the dilation and evacuation and intact dilation and extraction groups (4.9% vs. 5.0%; p = 1.0). The 6 complications occurring in the intact dilation and extraction group included 4 gential tract lacerations (3 cervical mucosal lacerations and one perineal laceration) noted and successfully repaired at the time of surgery; 1 case of excessive bleeding requiring return to the operating room on the day of surgery for curettage; and one patient readmitted due to heavy bleeding on postoperative day 13 who underwent dilation and curettage for retained placenta.

Complications in patients undergoing dilation and evacuation included 4 gential tract lacerations (2 cervical lacerations and 2 labial lacerations) noted and successfully repaired at the time of surgery; 2 cases of excessive bleeding requiring return to the operating room on the day of surgery (for curettage in 1 case, and repair of cervical lacertions in 1 case); 2 postoperative [8] admissions for intravenous antibiotics due to endometritis; 1 admission for observation following excessive bleeding; and 1 admission due to severe nausea from general anesthesia.

Three patients, all of whom underwent dilation and evacuation, had complications requiring admission to the surgical intensive care unit. One patient, with a fetal demise, had an amniotic fluid embolus with disseminated intravascular coagulation requiring transfusion of blood and clotting factors. One patient was diag-

nosed with sepsis and pulmonary embolus. One patient had a uterine perforation at the site of a cesarean delivery scar, and required exploratory laparotomy and blood transfusion.

45 women (17.1%) in the dilation and evacuation group and 17 women (15.0%) in the intact dilation and extraction group had a subsequent pregnancy and received care at our medical center. There were no second-trimester spontaneous abortions in either group. Spontaneous preterm birth occurred in 2 of 17 (11.8%) pregnancies in the intact dilation and extraction group compared to 2 of 45 (4.4%) in the dilation and evacuation group (p=0.30). Both spontaneous preterm births in the intact dilation and extraction group occurred in women at high-risk for prematurity: one woman, who underwent intact dilation and extraction due to PPROM at 23 weeks' gestation, subsequently delivered at 32 weeks; the other underwent intact dilation and extraction at 23 weeks' gestation due to cervical incompetence with advanced cervical dilation, and subsequently delivered at 35 weeks.

Discussion

Based on this series of 383 patients, surgical abortion late in the second trimester is a safe procedure. There were low rates of complications in procedures with either technique.

[9]

As described in a prior publication,[9] we did not see a high rate of spontaneous preterm birth in subsequent pregnancies in those who received obstetric care at our medical center.

Because this study was retrospective, we cannot state that one technique is superior to the other. Proce-

dures performed with intact dilation and extraction occurred at later gestational ages and with more preoperative cervical dilation. While more advanced gestation might be expected to increase complication rates, more preoperative cervical dilation might be expected to facilitate these procedures.

Differences between maternal age, gestational age, and indication for surgical abortion were noted between the two groups. The difference in gestational age may be due to changes in the cervix that occur as pregnancy progresses. With advancing gestation, the cervix may be more likely to respond to laminaria placement with greater dilation. Intact dilation and extraction requires more dilation, as the intact fetus cannot pass through a minimally dilated cervix. In addition, more women in the intact dilation and extraction group underwent abortion due to premature cervical dilation or PPROM. The incidence of these conditions increases with advancing gestation, and the spontaneous cervical dilation occurring in these cases probably facilitated intact dilation and extraction.

The difference in maternal age is likely due the higher rate of fetal aneuploidy in the dilation and evacuation group. Amniocentesis is typically performed at 16-18 weeks, and advanced maternal age is the most common indication. Most cases of fetal aneuploidy are identified by 20 weeks. This could explain why those in the dilation and evacuation group were older, and underwent abortion at earlier gestational ages.

Our approach of performing intact dilation and extraction when possible is intended to minimize the use of forceps in extracting the fetus. We believe that use of forceps to grasp the [10] fetus can cause inadvertent trauma to the uterine wall. At these gestational ages,

evacuation of a fetus can require multiple insertions of forceps, and intact dilation and extraction avoids this. Though we believe our low complication rate validates our approach, we acknowledge that the retrospective nature of this study precludes us from concluding with certainty that intact dilation and extraction prevented adverse outcomes.

Another important limitation is the relatively small number of patients receiving prenatal care at our hospital in subsequent pregnancies. Most patients returned to their referring obstetrician for future obstetric care, and we were unable to assess subsequent pregnancy outcomes of patients delivered at other institutions. We believe that significant bias as a result would be unlikely, though we cannot be certain that outcomes in pregnancies followed at our hospital are representative of outcomes in all subsequent pregnancies. Though we are reassured by the low number of complications in subsequent pregnancies in both groups, we acknowledge our lack of power to conclude that subsequent pregnancy outcomes are not different.

Some have stated that intact dilation and extraction poses serious risks to the health of a woman beyond the risks associated with dilation and evacuation. Such putative risks include higher rates of cervical incompetence, uterine rupture, abruption, amniotic fluid embolism, and trauma to the uterus.[6,7] We are not aware of any published data supporting these statements. In our patients, the overall rate of complications was comparable between those undergoing dilation and evacuation and intact dilation and extraction. No patient undergoing intact dilation and extraction experienced uterine rupture, amniotic fluid embolism, or required blood transfusion. Because our approach is to perform

intact dilation and extraction when possible based on cervical dilation and fetal position, it is unlikely that intact dilation and extraction could have [11] been performed in these patients undergoing dilation and evacuation who experienced severe complications.

In conclusion, our data affirm that abortion after 20 weeks' gestation with intact dilation and extraction appears to have similar complication rates as dilation and evacuation when performed by experienced physicians. The observed complication rates and subsequent obstetric outcomes appear comparable between the two techniques. In accordance with the American College of Obstetricians and Gynecologists (ACOG) statement of policy,[9] our data supports that the most appropriate technique for surgical evacuation of pregnancy after 20 weeks' gestation should be based on intraoperative factors. Attempts to regulate intact dilation and extraction based on concern for maternal well-being cannot be supported by available evidence.

[12]

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[13]

Table I. Demographic characteristics of patients undergoing dilation and evacuation.

	D&E (n=263)	D&X (n=120)	p value
Median Maternal Age (range)	34 years (16-45)	32 years (12-43)	0.01*
Median Parity (range)	0 (0-7)	1 (0-5)	0.04*
Median Gestational Age at dilation and evacuation (range)	21 weeks (20-27)	23 weeks (20-25)	<0.001*
Prior Vaginal Delivery	81 (30.8%)	50 (41.7%)	0.05*
Prior Cesarean Delivery	49 (18.6%)	26 (21.7%)	0.49*
Multifetal Pregnancy	13 (4.9%)	8 (6.7%)	0.48*

*Mann-Whitney U test

†Fisher's exact test

D & E = Dilation and evacuation

D& X = Intact dilation and extraction

[14]

Table II. Indication for dilation and evacuation*

Indication for dilation and evacuation	D&E (n=263)	D&X (n=120)	p value†
Abnormal fetal karyotype	112 (42.6%)	33 (27.5%)	0.005
Structural fetal abnormality	96 (36.5%)	47 (39.2%)	0.65
Intrauterine fetal demise	27(10.3%)	14 (11.7%)	0.72
Premature cervical dilation/PPROM	14 (5.3%)	20 (16.7%)	0.001
Other	22 (8.4%)	13 (10.8%)	0.45

*Some patients had more than one indication

†Fisher's exact test

D & E = Dilation and evacuation

D & X = Intact dilation and extraction

[15]

Table III. Intraoperative variables

	D&E (n=263)	D&X (n=120)	p value
Laminaria	259 (98.5%)	109 (90.8%)	0.001*
Median Preoperative Cervical Dilation (range)	3 cm (0-6)	5 cm (2-10)	<0.001*
Anesthesia			
General	92 (35.05%)	53 (44.2%)	0.22**
Regional	9 (3.4%)	3 (2.5%)	
Local/Conscious Sedation	162 (61.6%)	64 (53.3%)	
Median Procedure Time (range)	22 minutes (6-60)	22 minutes (6-45)	0.54*
Median Estimated Blood Loss (range)	100 ml (40-1500)	100 ml (20-1200)	0.38*

*Mann-Whitney U test

**Fisher's exact test

***Chi-square anlaysis

D & E = Dilation and evacuation

D & X = Intact dilation and extraction

UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF
CALIFORNIA SAN FRANCISCO DIVISION

Civil Action No. 03-4872 PJH

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. AND PLANNED PARENTHOOD GOLDEN GATE, PLAINTIFFS

v.

JOHN ASHCROFT, ATTORNEY GENERAL OF THE UNITED STATES, IN HIS OFFICIAL CAPACITY, DEFENDANT

Nov. 13, 2003

SUPPLEMENTAL COMPLAINT

Pursuant to stipulation of the parties and leave of Court granted at the specially-set hearing on November 6, 2003, *see* Order Granting Plaintiffs Motion for Temporary Restraining Order at 1 n.1 (Nov. 7, 2003), and pursuant to Rule 15(d) of the Federal Rules of Civil Procedure, Plaintiffs, by and through their attorneys, bring this supplemental complaint against the above-named Defendant, his employees, agents, and successors in office, and in support thereof state the following:

I. INTRODUCTORY STATEMENT

1. This is a constitutional challenge to S.3, the "Partial-Birth Abortion Ban Act of 2003" (to be codified at 18 U.S.C. § 1531) [hereinafter "the Act"]. The Act passed the House and the Senate and was signed by

President Bush on November 5, 2003. It became effective at 12:01 a.m. on November 6, 2003. A copy of the Act is attached as Exhibit A.

2. Plaintiffs seek declaratory and injunctive relief against the Act, which bans what the Act calls "partial-birth abortion." Those physicians who provide banned abortions risk criminal penalties and civil liability. The Act must be enjoined and declared unconstitutional because if suffers from the identical two constitutional flaws as the Nebraska statute banning so-called "partial-birth abortion" that was struck down by the United States Supreme Court in *Stenberg* v. *Carhart*, 530 U.S. 914 (2000).

3. First, in contravention of the Supreme Court's clear holding, the Act bans abortion procedures without providing any exception for when such procedures are necessary or appropriate for the pregnant woman's health and without providing an adequate exception to protect women's lives. The Act thus deprives physicians of the discretion they need to make appropriate medical judgments regarding which abortion procedure to use, and requires physicians to use methods of abortion that impose unnecessary health risks upon patients.

4. Second, the term "partial-birth abortion," which is not a recognized medical term, is defined so broadly in the Act as to chill physicians from providing the safest and most common methods of abortion used in the second trimester of pregnancy prior to viability. The Act thus imposes an "undue burden" on the right to obtain previability abortions. Alternatively, the Act is so vague that it fails to give physicians fair warning of which abortion procedures are prohibited.

5. For these reasons, the Act violates the rights of Plaintiffs, their employees, their agents, and their patients to privacy and due process guaranteed under the Fifth Amendment of the United States Constitution.

II. JURISDICTION AND VENUE

6. Jurisdiction is conferred on this Court by 28 U.S.C. § 1331.

7. Plaintiffs' claim for declaratory and injunctive relief is authorized by 28 U.S.C. §§ 2201 and 2202, by Rules 57 and 65 of the Federal Rules of Civil Procedure, and by the general legal and equitable powers of this Court.

8. Venue is appropriate under 28 U.S.C. § 1391(e) because administrative offices and healthcare facilities of Plaintiffs Planned Parenthood Golden Gate (PPGG) are located in this district, and PPGG provides abortions that may be banned under the Act in this district. Plaintiff Planned Parenthood Federation of America (PPFA) has a national office located in this district. Therefore, a substantial part of the events or omissions giving rise to the Plaintiffs' claims occur in this district.

III. PARTIES

A. Plaintiffs

9. Plaintiff PPFA is a not-for-profit corporation organized under the laws of New York. One of PPFA's national offices is located in San Francisco, California. PPFA is the leading national voluntary health organization in the field of reproductive health care. PPFA has 125 member-affiliates in 49 states and the District of Columbia. Cumulatively, Planned Parenthood's member-affiliates serve over 2.5 million patients per year.

Some Planned Parenthood member-affiliates provide second-trimester abortions that fall within the proscriptions of the Act, including dilation and evacuation (D&E) abortions, which are the most common method for performing abortions in the second-trimester of pregnancy. These Planned Parenthood member-affiliates reasonably fear that if they continue to provide second-trimester abortions, they and their employees and agents will risk criminal prosecution and civil liability under the Act. Some Planned Parenthood member-affiliates train medical residents in the provision of second-trimester abortions. These member-affiliates reasonably fear that if they continue to train residents in the provision of second-trimester abortions, they and their employees and agents, and the medical residents and their faculty supervisors, will risk criminal prosecution and civil liability under the Act. PPFA sues on its own behalf, on behalf of its member-affiliates that provide second-trimester abortions, on behalf of all current and future physicians, medical residents and their faculty supervisors, and all member-affiliate employees, staff, servants, officers, and agents who perform, participate or assist in the performance of, supervise, and/or train in the provision of, second-trimester abortion services at Planned Parenthood member-affiliates and/or on Planned Parenthood patients, and who are at risk of criminal prosecution and civil lawsuits under the Act, and on behalf of patients seeking abortions at Planned Parenthood member-affiliates nationwide.

10. Plaintiff PPGG is a health care provider that provides clinical, educational, and counseling services to men and women at 7 health care centers in the Northern Bay Area. PPGG provides a full range of reproduc-

tive health services, including: pregnancy diagnosis and counseling; contraceptive counseling; provision of all methods of contraception; HIV/AIDS testing and counseling; testing, diagnosis, and treatment of sexually transmitted infections; support services for pregnant women; cancer screening for cervical and breast cancer; colposcopy and cryosurgergy; and abortion services through 18 weeks of pregnancy as measured from the first day of the woman's last menstrual period (LMP), including D&E abortions. PPGG also provides primary care services. PPGG employs and/or contracts with physicians who perform second-trimester abortion procedures that may fall within the proscriptions of the Act, including D&E abortions. PPGG and its employees, staff, servants, and agents reasonably fear that if they continue to provide second-trimester abortion procedures, they will suffer criminal prosecution and civil lawsuits under the Act. PPGG sues on its own behalf, on behalf of its current and future physicians, medical residents and their faculty supervisors, and all PPGG employees, staff, servants, officers, and agents who perform, participate or assist in the performance of, supervise, and/or train in the provision of, second-trimester abortion services at PPGG facilities and/or on PPGG patients and who are at risk of criminal prosecution and civil lawsuits under the Act, and on behalf of its patients.

B. Defendant

11. Defendant John Ashcroft is the Attorney General of the United States and heads the United States Department of Justice, which is the agency of the United States government responsible for enforcement of federal laws, including the Act. Defendant Ashcroft is sued in his official capacity, as are his successors.

IV. THE STATUTORY FRAMEWORK

12. The Act makes it a crime for any physician "in or affecting interstate or foreign commerce," to "knowingly perform[] a partial-birth abortion." 18 U.S.C. § 1531(a). A "partial-birth abortion" is defined as:

> an abortion in which the person performing the abortion—
>
> (A) deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and
>
> (B) performs the overt act, other than completion of delivery, that kills the partially delivered living fetus . . . .

18 U.S.C. § 1531(b)(1). This prohibition applies throughout pregnancy, regardless of fetal viability.

13. The Act contains a single limited exception. Only where a so-called partial-birth abortion "is necessary to saved the life of a mother whose life is endangered by a physical disorder, physical illness, or physical injury" is the Act inapplicable. 18 U.S.C. § 1531(a). The exception does not appear to apply to the Act's civil penalties.

14. Violation of the Act is punishable by up to two years imprisonment or a fine, or both. 18 U.S.C. § 1531(a).

15. In addition to criminal penalties, the Act provides for civil lawsuits. It allows the woman's husband, if she is married, or her parents, if she is under 18 years of age, to bring a civil action against any physician who allegedly performs a so-called "partial-birth abortion." 18 U.S.C. § 1531(c)(1). The plaintiff in such a lawsuit may seek, *inter alia*, money damages for "all injuries, psychological and physical," resulting from the so-called "partial-birth abortion." 18 U.S.C. § 1531(c)(2). A person whose criminal conduct caused the pregnancy or a person who consents to the abortion cannot be a plaintiff in such a civil action. 18 U.S.C. § 1531(c)(1). This provision thus operates as a *de facto* spousal and/or parental consent requirement for second-trimester abortions.

16. Pursuant to federal law establishing accessory and accomplice liability, Planned Parenthood member-affiliates, and employees, staff, servants, officers, or agents of member-affiliates that assist in the performance of abortions or supervise abortions, and/or medical residents and their faculty supervisors that are training in the provision of abortions at Planned Parenthood member-affiliates, could be prosecuted and/or sued in a civil action under the Act for any abortion performed at a Planned Parenthood member-affiliate and/or on a Planned Parenthood patient that is deemed to violate the Act.

V. THE EFFECTS OF THE ACT

A. Effect on Women's Health

17. Women seek abortions for a variety of deeply personal reasons, including the inability or hardship of raising a child, the fact that the pregnancy results from rape or incest, because continuing the pregnancy

threatens their lives and/or health, or because they are carrying a fetus with congenital anomalies. For all these women, the inability to obtain an abortion due to the Act would be devastating.

18. The effect of the Act on women seeking later abortions would be particularly tragic. Although only about 12% of abortions performed nationwide occur in the second trimester of pregnancy, women seeking these abortions are frequently in difficult life circumstances. For example, women carrying fetuses with serious abnormalities such as anencephaly (absence of a brain) or trisomies 13 and 18 (chromosomal abnormalities that cause multiple disabilities and mental retardation) are forced to seek abortions in the second trimester because the diagnosis of the abnormalities is not possible, or much more difficult, until then. In addition, women may be seeking abortions to avert a risk to their health, which may not have arisen or become apparent until the second trimester.

19. Women face other hurdles that may delay their ability to seek an abortion. For example, a woman may have been unable to raise the funds for the abortion earlier in pregnancy. Many women must travel long distances for an abortion due to the severe shortage of abortion providers. Arranging for an abortion in a distant city may be time-consuming. Many women delay having abortions due to the difficulty in taking time off work and/or arranging for child care. A disproportionate number of women seeking second trimester abortions are teenagers, who do not recognize the signs of pregnancy, or ignore or deny them, or are delayed by lack of funds or reluctance to involve their parents.

20. The sole exception to the Act's ban is ineffective to protect women's life and health. The exception permits a physician to perform a so-called "partial-birth abortion" only when it "is necessary to save the life of a mother whose life is endangered by a physical disorder, physical illness, or physical injury." 18 U.S.C. § 1531(a). The flaws in this exception are several. First, the Act fails to allow a banned abortion when the woman's health is endangered by the pregnancy but the physician cannot certify that her life is threatened. For example, the condition of a woman with heart disease or diabetes may deteriorate during a pregnancy to the point where, if the pregnancy is allowed to progress to term, she may suffer permanent cardiac or kidney impairment, yet she might survive. In such circumstances, an abortion may be warranted to save a woman's health, although her life is not at risk. But the Act does not permit a banned procedure in this situation. The Act, therefore, imposes severe criminal penalties on a physician who acts according to his or her best medical judgment.

21. Second, the Act does not permit a banned procedure where, regardless of the woman's health status, in the best medical judgment of the physician, that procedure would be the safest or most medically appropriate for a particular patient. It may, therefore, force women to undergo riskier procedures. It thus fails to protect the health of women seeking abortions.

22. Third, the Act does not even adequately protect women's lives because it may be read as allowing use of a banned procedure only when the so-called "partial-birth abortion" is literally "necessary" to save a woman's life, and thus procedures that are not strictly "necessary," because another—albeit riskier—abortion

procedure (such as hysterotomy or hysterectomy) is available, would be banned.

23. Fourth, the inadequacy of the exception is exacerbated by its failure to provide any mens rea requirement for the finding that a "partial-birth abortion" is "necessary" to save the pregnant woman's life. Given the "is necessary" standard, a physician who relies on his or her best medical judgment that an abortion is necessary for the woman's life may face severe criminal penalties if other physicians disagree about the necessity of the procedure. The lack of a mens rea requirement is likely to chill the provision of lifesaving health care.

24. Even if the Act bans only D&E abortions in which the fetus remains intact or largely intact when it is extracted from the uterus (sometimes referred to as intact D&E or dilation and extraction ["D&X"] abortions), an adequate life and health exception is necessary. This is because such abortions may be the safest for some women in some circumstances.

B. Effect on Women's Access to Abortion and other Medical Services

25. The actions that the Act defines as constituting a "partial-birth abortion" could occur in any D&E abortion, including but not limited to intact D&E abortions, as well as in any induction abortion. (As used in this complaint, the term "D&E" includes "intact D&Es," and the term "intact D&E" is interchangeable with the term "D&X.") This is because:

(a) in all D&E or induction abortions, the person performing the abortion "deliberately and intentionally vaginally delivers a . . . fetus," 18 U.S.C. §

1531(b)(1)(A), and in many instances, the fetus is "living" when that occurs;

(b) in any D&E or induction abortion, the fetus, while still "living," may emerge until "in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother," *id.*;

(c) in many instances—whether the abortion is a D&E or induction procedure—after the fetus has emerged to the point that the Act specifies, the physician may "perform[] an overt act," *id.*, short of completing the delivery, that the physician knows may result in fetal demise, and then will complete the procedure. This "overt act" (regardless of whether the procedure is a D&E or induction abortion) could involve: collapsing the calvarium (fetal skull) to enable it to be brought through the cervical os (opening), cutting the umbilical cord, or disarticulating a piece of the fetus; and

(d) the physician's "purpose," *id.*, in performing any abortion procedure—whether D&E, intact D&E or induction—is not to perform any particular act. Rather, the purpose in any abortion is the same: to complete the delivery as safely and quickly as possible. The "purpose" language therefore does not limit the Act's reach.

26. While not all D&E or induction abortions will proceed in a manner that violates the Act, physicians cannot know or predict in advance which abortions will so proceed. Accordingly, performing any D&E or

induction abortion places doctors at risk of violating the Act.

27. Together, D&E and induction abortions account for more than 95% of previability abortions performed in the second trimester of pregnancy.

28. If neither D&E nor induction abortions were available, the only remaining abortion option for women in the second trimester of pregnancy would be hysterotomy or hysterectomy. Hysterectomy involves making a surgical incision into the uterus to deliver the fetus. Hysterectomy involves surgical removal of the entire uterus. As major abdominal surgery, both hysterotomy and hysterectomy involve many times the risk of either D&E or induction procedures, and must be performed in a hospital. Moreoever, hysterectomy precludes future childbearing. For those reasons, they have been virtually abandoned as methods of abortion.

29. If the Act were to take effect, Plaintiffs would be chilled from providing D&E or induction abortions because of the reasonable fear of criminal prosecution and civil liability under the Act. It therefore imposes an undue burden on women seeking second-trimester abortions.

30. The Act's definition of "partial-birth abortion" fails to give Plaintiffs fair warning as to what conduct is prohibited. In addition, the Act fails to give fair warning as to what conduct is "in or affecting interstate . . . commerce." The Act thus forces physicians to guess—under threat of criminal prosecution and civil liability—whether performing an accepted medical procedure falls within the Act's proscription. Moreover, because of the Act's vagueness, prosecuting attorneys may differ widely as to what conduct they believe is

proscribed by the Act. It thus subjects Plaintiffs to arbitrary and discriminatory prosecution.

31. If the Act is allowed to take effect, access to abortions in the second trimester of pregnancy—with the exception of hysterotomy and hysterectomy—would be severely curtailed in the United States because Plaintiffs and other abortion providers would be chilled from performing D&E and induction abortion procedures in the safest manner because doing so could result in a procedure that is banned by the Act. This would prevent some women from obtaining an abortion altogether; delay some women who decide to go out of the country or to a distant part of this country, to obtain a safe second-trimester abortion, thus increasing the medical risks of the procedure; and force some women to have relatively riskier abortion procedures, increasing the possibility of damage to their lives and health.

32. If the Act were to take effect, it could also chill physicians from providing necessary medical care to women who present at the hospital in the middle of a second trimester miscarriage because the medical assistance provided to complete the miscarriage could violate the terms of the Act.

33. If the Act were to take effect, physicians may be compelled to obtain parental and/or spousal consent to all D&E abortions performed on women under the age of 18 and married women in order to avoid the risk of civil lawsuits by a parent and/or spouse whose daughter/wife had an abortion that the parent and/or spouse contends is a so-called "partial-birth abortion."

VI. INJUNCTIVE RELIEF

34. Plaintiffs have no adequate remedy at law and will suffer irreparable harm for continued violations of their and their patients' constitutional rights if the Act goes into effect.

35. Enforcement of the Act will cause irreparable harm by threatening Plaintiffs with criminal prosecution and civil liability for providing, teaching, participating in, assisting in, or supervising the provision of abortion services in the second trimester of pregnancy, thereby chilling the provision of those services; prevent some patients from receiving abortion services in the second trimester; force some women to obtain medical care that is more dangerous and/or more likely to deprive them of the ability to bear children in the future; delay other women in obtaining abortions, thus increasing the medical risks to their life or health; deprive women of their right to determine the course of their own medical treatment; and compel doctors to abridge patient confidentiality by obtaining parental and/or spousal consent to the abortion in order to avoid potential civil liability.

VII. FIRST CLAIM FOR RELIEF

36. Plaintiffs hereby incorporate by reference Paragraphs 1 through 35 above.

37. By prohibiting health care facilities and physicians, at any stage of pregnancy, from performing so-called "partial-birth abortions" where necessary to preserve the woman's health or where that procedure would be the most medically appropriate for the woman, and by limiting the circumstances under which a physician can perform a so-called "partial-birth abortion" to preserve the woman's life, the Act violates the

right of women to privacy, life, and liberty guaranteed by the Due Process Clause of the Fifth Amendment.

VIII. SECOND CLAIM FOR RELIEF

38. Plaintiffs hereby incorporate by reference Paragraphs 1 through 37 above.

39. By prohibiting health care facilities and physicians from performing so-called "partial-birth abortions," at any time during pregnancy, the Act has the purpose and effect of imposing an undue burden on women's right to choose abortion, in violation of their right to privacy and liberty guaranteed by the Due Process Clause of the Fifth Amendment.

IX. THIRD CLAIM FOR RELIEF

40. Plaintiffs hereby incorporate by reference Paragraphs 1 through 39 above.

41. By depriving women who have already decided to have a pre-viability abortion of the right to have the medically accepted abortion procedure of their choice, and by forcing women to obtain abortion procedures that are medically riskier, more intrusive, and more painful than those banned by the Act, the Act violates the right to bodily integrity guaranteed by the Due Process Clause of the Fifth Amendment.

X. FOURTH CLAIM FOR RELIEF

42. Plaintiffs hereby incorporate by reference Paragraphs 1 through 41 above.

43. By failing to give adequate notice of the procedures it proscribes, and by encouraging arbitrary enforcement, the Act is impermissibly vague, thereby violating the right of Plaintiffs and their employees and

agents to due process, as guaranteed by the Fifth Amendment.

WHEREFORE, Plaintiffs ask this Court:

A. To issue a temporary restraining order, a preliminary injunction, and a permanent injunction restraining Defendant, his employees, agents, and successors from enforcing the challenged Act;

B. To enter judgment declaring the challenged Act to be in violation of the United States Constitution;

C. To grant such other and further relief as this Court should find just and proper, including attorneys' fees and costs.

DATED: November 13, 2003

BINGHAM McCUTCHEON LLP
PLANNED PARENTHOOD
FEDERATION OFAMERICA

By: /s/ BETH H. PARKER
BETH H. PARKER
Attorneys for Plaintiffs
Planned Parenthood
Federation of America, Inc.
and Planned Parenthood
Golden Gate

UNITED STATES DISTRICT COURT FOR THE
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

No. C 03-4872 PJH

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC. AND PLANNED PARENTHOOD GOLDEN GATE, PLAINTIFFS

v.

JOHN ASHCROFT, ATTORNEY GENERAL OF THE UNITED STATES, IN HIS OFFICIAL CAPACITY, DEFENDANT

Trial Date: Mar. 29, 2004
Courtroom: Judge Phyllis J. Hamilton
E-FILING

STIPULATION AND ORDER

The parties hereby stipulate, by and through their attorneys, that the designations and counter-designations of the following deponents, previously identified and provided to the Court, be filed with the Clerk of the Court along with the exhibits attached to the designations:

Rebecca Baergen, M.D.

Alan Baker (APHA)

Joanna Cain, M.D. (ACOG)

Steven L. Clark, M.D.

Marilyn Conners Frederiksen, M.D.

Amos Grunebaum, M.D.
Cassing Hammond, M.D.
Meghan Kissel (AMWA)
Wan Joo Kim
Charles J. Lockwood, M.D.
William Moschella
John Whitelaw, M.D. (CMA)

The parties attach as Exhibit A the page/line designations and counter-designations for Steven L. Clark, M.D., and Charles J. Lockwood, M.D. These were not previously filed with the Court.

DATED: June 4, 2004

BINGHAM McCUTCHEN LLP
PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.

By: BETH H. PARKER
BETH H. PARKER
Attorneys for Plaintiffs Planned Parenthood Federation of America, Inc. and Planned Parenthood Golden Gate

DATED: June 4, 2004

DEPARTMENT OF JUSTICE

By: SCOTT SIMPSON
SCOTT SIMPSON
Attorneys of Defendant John Aschroft

IT IS SO ORDERED

PHYLLIS J. HAMILTON

PHYLLIS J. Hamilton
United States District Judge

Date: 6/8/04

BINGHAM McCUTCHEN

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March 24, 2004

Via Facsimile

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Re: PPFA v. Aschroft

Dear Mark and Scott:

Below are the designations for Dr. Clark we are providing to the Court today:

Steven Clark, M.D., Counter Designations

7:12-19
12:2-14
13:3-19
15:8-12
18:23-19:5
21:4-5
21:25-22:4, 10-16
24:3-10
25:2-13
30:3-9
35:9-24
36:11-14
37:14-16, 37 -38:3, 9-14
40:5-24
41:3-42-1
43:20-44:2
49:12-22
52:22-53:1, 11-12
54:19-23
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61:5-9, 14-20
87:5-21
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96:7-12
97:8-11

98:6-10
103:13-25
112:3-6
131:16-132:7
144:11-14
144:22-145:1
145:14-146:15
147:4-23
168:13-18
173:12-174:11
178:15-179:21
190:20-191:1

Sincerely,

/s/ BETH H. PARKER
BETH H. PARKER

cc: Eve Gartner

Defendant's Designations: Steven L. Clark, M.D.

1:14-19
10:23-12:1
12:15-13:2
13:20-15:7
16:11-18:22
19:7-20
22:17-24:2
24:11-25:1
28:1-23
29:21-30:2 (Beginning with "Do you use...")
31:13-33:1
33:13-34:14
34:16-35:2
35:16-37:13
39:12-25
44:8-25
45:20-46:14
47:8-14
47:16-48:6
48:8-49:18
52:6-21
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123:11-12
123:15-124:7
124:9-125:8
125:21-126:19
127:17-20
127:22-128:7
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129:13-130:1
130:3-21
130:23-131:11
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133:3-6
133:8-134:12
134:14-21
135:4-10
135:12-23
136:7-9
136:11-137:1

137:3-20
137:22-138:7
138:9-139:16
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142:16-143:5
145:2-13
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182:22-23
182:25-183:8
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187:10-190:19

Defendant's Designations: Charles J. Lockwood, M.D.

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6:4-9
7:10-13
26:24-29:23
72:17-76:6
79:18-80:22
81:6-83:22
86:16-88:3
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200:14-202:23
203:12-205:23

Supreme Court, U.S.
FILED
AUG 3 2006
OFFICE OF THE CLERK

No. 05-1382

In the Supreme Court of the United States

ALBERTO R. GONZALES, ATTORNEY GENERAL,
PETITIONER

v.

PLANNED PARENTHOOD FEDERATION OF AMERICA,
INC., ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF FOR THE PETITIONER

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QUESTION PRESENTED

The Partial-Birth Abortion Ban Act of 2003 (the Act), Pub. L. No. 108-105, 117 Stat. 1201 (18 U.S.C. 1531 (Supp. III 2003)), prohibits a physician from knowingly performing a "partial-birth abortion" (as defined in the statute) in or affecting interstate commerce. § 3, 117 Stat. 1206-1207. The Act contains an exception for cases in which the abortion is necessary to preserve the life of the mother, but no corresponding exception for the health of the mother. Congress, however, made extensive factual findings, including a finding that "partial-birth abortion is never medically indicated to preserve the health of the mother." § 2(14)(O), 117 Stat. 1206. The question presented is as follows:

Whether, notwithstanding Congress's determination that a health exception was unnecessary to preserve the health of the mother, the Partial-Birth Abortion Ban Act of 2003 is invalid because it lacks a health exception or is otherwise unconstitutional on its face.

PARTIES TO THE PROCEEDING

Petitioner is Alberto R. Gonzales, Attorney General of the United States. Respondents are Planned Parenthood Federation of America, Inc.; Planned Parenthood Golden Gate; and the City and County of San Francisco.

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In the Supreme Court of the United States

No. 05-1382

ALBERTO R. GONZALES, ATTORNEY GENERAL,
PETITIONER

v.

PLANNED PARENTHOOD FEDERATION OF AMERICA,
INC., ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF FOR THE PETITIONER

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-54a) is reported at 435 F.3d 1163. The opinion and order of the district court (Pet. App. 55a-218a) are reported at 320 F. Supp. 2d 957.

JURISDICTION

The judgment of the court of appeals was entered on January 31, 2006. The petition for a writ of certiorari was filed on May 1, 2006, and was granted on June 19, 2006. The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

STATUTORY PROVISIONS INVOLVED

The Partial-Birth Abortion Ban Act of 2003, Pub. L. No. 108-105, 117 Stat. 1201 (18 U.S.C. 1531 (Supp. III 2003)), is set forth in an appendix to this brief.

STATEMENT

Like *Gonzales* v. *Carhart*, cert. granted, No. 05-380 (Feb. 21, 2006), this case concerns the constitutionality of the federal Partial-Birth Abortion Ban Act of 2003. That Act prohibits a physician from knowingly performing a partial-birth abortion—a particular abortion procedure that Congress found to be "gruesome and inhumane" and to "blur[] the line between abortion and infanticide in the killing of a partially-born child just inches from birth." Act §§ 2(1), 2(14)(O), 117 Stat. 1201, 1206. Because Congress found, *inter alia*, that partial-birth abortion is "never medically indicated to preserve the health of the mother," § 2(14)(O), 117 Stat. 1206, it did not adopt a statutory exception for cases in which the abortion is necessary to preserve the mother's health. Like the court of appeals in *Carhart*, the court of appeals in this case held that, notwithstanding Congress's finding, the Act was facially invalid because it lacked a health exception. The court of appeals in this case, however, went further and also held that the Act was facially invalid on the grounds that it was unconstitutionally overbroad (because it reached certain other abortions besides partial-birth abortions) and unconstitutionally vague (because it could be read to reach other abortions). The court of appeals additionally held that it could not craft a narrower injunction, and therefore permanently enjoined enforcement of the Act in its entirety. Like the court of appeals' decision in *Carhart*, the court of appeals' decision in this case should be reversed.

1. The factual background to Congress's enactment of the Act is set forth at greater length in the government's brief in *Carhart* (at 2-4). The phrase "partial-birth abortion" refers to a late-term abortion procedure known as dilation and extraction (D&X) or intact dilation and evacuation (intact D&E). In that procedure, a physician partially delivers the fetus

intact and then intentionally kills it, typically by puncturing its skull and vacuuming out its brain. See, *e.g.*, J.A. 73, 282-283, 454-455, 480-481.

After years of hearings and debates, Congress passed, and the President signed, the Partial-Birth Abortion Ban Act of 2003. In *Stenberg* v. *Carhart*, 530 U.S. 914 (2000), this Court had invalidated a Nebraska statute that banned "partial birth abortion" (as defined in that statute) unless the procedure was necessary to preserve the life of the mother. In drafting the Act, Congress deliberately sought to remedy the deficiencies identified by this Court in the statute at issue in *Stenberg*, and the Act differs from that statute in two principal ways.

First, based on "the testimony received during extensive legislative hearings during the 104th, 105th, 107th, and 108th Congresses," Act § 2(14), 117 Stat. 1204, the Act contains detailed factual findings with respect to the medical necessity of partial-birth abortion. Congress found, *inter alia*, that "[p]artial-birth abortion poses serious risks to the health of a woman undergoing the procedure," § 2(14)(A), 117 Stat. 1204; that "[t]here is no credible evidence that partial-birth abortions are safe or are safer than other abortion procedures," § 2(14)(B), 117 Stat. 1204; and that "[t]he physician credited with developing the partial-birth abortion procedure has testified that he has never encountered a situation where a partial-birth abortion was medically necessary to achieve the desired outcome," § 2(14)(E), 117 Stat. 1204-1205. Based on those and other findings, Congress ultimately found that "partial-birth abortion is never medically indicated to preserve the health of the mother," § 2(14)(O), 117 Stat. 1206. In the Act's operative provisions, therefore, Congress did not include an express statutory exception for cases in which the abortion is necessary to preserve the mother's health. § 3, 117 Stat. 1206 (18 U.S.C. 1531(a) (Supp. III 2003)).

Second, the Act contains the following, more specific definition of "partial-birth abortion":

> an abortion in which the person performing the abortion—(A) deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and (B) performs the overt act, other than completion of delivery, that kills the partially delivered living fetus.

Act § 3, 117 Stat. 1206-1207 (18 U.S.C. 1531(b)(1) (Supp. III 2003)). That definition is tailored to exclude the more common standard D&E procedure, in which the physician dismembers the fetus while the remainder of the fetus is still in the womb. The Act imposes criminal and civil sanctions only on a physician who knowingly performs a partial-birth abortion. § 3, 117 Stat. 1206 (18 U.S.C. 1531(a) (Supp. III 2003)).

2. Respondents Planned Parenthood Federation of America, Inc., and Planned Parenthood Golden Gate brought suit against the Attorney General, seeking a permanent injunction against enforcement of the Act. Respondent City and County of San Francisco subsequently intervened as a plaintiff. Respondents asserted that the Act was facially invalid under the Fifth Amendment on the grounds that, *inter alia*, (1) it imposed an undue burden on a woman's access to an abortion because it lacked an express statutory health exception; (2) it imposed an undue burden because it prohibited not only D&X abortions, but also certain other abortions; and (3) it was unconstitutionally vague in various respects.

After a bench trial, the district court granted judgment to respondents and entered a permanent injunction barring the

government from enforcing the Act against respondents and their employees. Pet. App. 55a-218a. The district court agreed with respondents that the Act was facially invalid on all three grounds.

The district court first held that the Act was facially invalid because it lacked a health exception. Pet. App. 96a-217a. After reviewing the evidence presented at trial, the district court found that "plaintiffs have not demonstrated the existence of any particular situation * * * in which an intact D&E would be a doctor's *only* option to preserve the life or health of a woman." *Id.* at 147a (emphasis added). Nevertheless, the court also found that "intact D&E is in fact the safest medical option for some women in some circumstances." *Ibid.* The court rejected the government's argument that Congress's factual findings—including its ultimate finding that partial-birth abortion was never medically indicated to preserve the health of the mother—were entitled to deference. *Id.* at 156a-213a.

The district court further held that the Act was facially invalid because it was unconstitutionally overbroad and therefore would impose an undue burden. Pet. App. 73a-89a. The court explained that "[p]hysicians may perform each element contained in the Act's definition [of 'partial-birth abortion'] in any D&E procedure, and in the course of certain induction abortions and treatment of spontaneous miscarriages as well." *Id.* at 85a. The court thus concluded that the Act's definition "encompasses several second trimester abortion procedures *in addition* to intact D&E." *Ibid.* The court added that, "even assuming that the Act covers only the intact D&E procedure, the Act does not distinguish between previability and postviability." *Id.* at 88a. "To the extent that a woman seeks or requires an intact D&E abortion prior to viability," the court reasoned, "this Act would undoubtedly place a substantial obstacle in her path and decision." *Id.* at 88a-89a.

Finally, the district court held that the Act was facially invalid because it was unconstitutionally vague. Pet. App. 89a-96a. The court stated that "the Act fails to clearly define the prohibited procedures and does not use terminology that is recognized in the medical community." *Id.* at 89a. The court explained that "the term 'partial-birth abortion' has little if any medical significance in and of itself," *id.* at 92a; "the term 'living fetus' adds to the vagueness of the statute, since, the term 'living fetus' * * * does not pertain to viability," *id.* at 93a; and "the requirement of an 'overt act' [does not] sufficiently narrow the scope of the Act to give notice of the type of abortion procedure prohibited," *ibid.* The court also stated that "the Act's vagueness and unconstitutional breadth cannot be cured by the alleged scienter requirements." *Id.* at 94a.

3. The court of appeals affirmed. Pet. App. 1a-54a.

a. As to the lack of a health exception, the court of appeals construed this Court's decision in *Stenberg* as holding that "an abortion regulation that fails to contain a health exception is unconstitutional except when there is a medical consensus that no circumstance exists in which the procedure would be necessary to preserve a woman's health." Pet. App. 15a. The court of appeals acknowledged that Congress had made various factual findings concerning the necessity of a health exception, but declined to defer to those findings. *Id.* at 17a. "Under even the most deferential standard of review," the court rejected Congress's threshold finding that "[a] moral, medical, and ethical consensus exists that the practice of performing a partial-birth abortion * * * is never medically necessary," Act § 2(1), 117 Stat. 1201. Pet. App. 19a. The court explained that "evidence of the lack of medical consensus is replete throughout th[e] [legislative] record." *Ibid.* The court likewise rejected, as inconsistent with *Stenberg*, the government's submission that the court should in any event

defer to Congress's ultimate (and dispositive) finding that "partial-birth abortion is never medically indicated to preserve the health of the mother," Act § 2(14)(O), 117 Stat. 1206. Pet. App. 21a-22a.

As to overbreadth, the court of appeals reasoned that, in *Stenberg*, this Court "provided legislatures with guidance about how to draft statutes that would adequately distinguish between" D&X and standard D&E abortions. Pet. App. 24a. In the court of appeals' view, this Court "explained that a legislature can make clear that a statute * * * applies to [D&X abortions]" either by using language that tracks the medical differences between the two types of abortion or by providing an express exception for standard D&E abortions. *Ibid.* The court of appeals concluded that "Congress deliberately chose not to follow the Court's guidance" in drafting the Act. *Id.* at 25a. Instead, the court of appeals asserted, "Congress defined the prohibited procedure in a way that * * * includes both intact and non-intact D&Es." *Ibid.*

The court of appeals rejected the government's contention that the Act differed from the Nebraska statute at issue in *Stenberg* because it contained a narrower and more specific definition of the prohibited procedure. Pet. App. 26a-27a. The court reasoned that, "in non-intact D&Es, a doctor may extract a substantial portion of the fetus—including either a part of the fetal trunk past the navel or the entire fetal head—to the point where it is outside the body of the mother before the fetal disarticulation occurs." *Id.* at 27a. The court further reasoned that such subsequent "disarticulation" (*i.e.*, dismemberment) could constitute an "overt act" that kills the living fetus. *Id.* at 30a. Because "the Act covers non-intact as well as intact D&Es," the court concluded, it imposed an undue burden on a woman's access to an abortion. *Ibid.*

As to vagueness, the court of appeals stated that "the language of the statute, taken as a whole, is not sufficiently clear

regarding what it permits and prohibits to guide the conduct of those affected by its terms." Pet. App. 34a. The court reasoned that the Act's operative provisions were vague because the Act "could readily be applied to a range of methods of performing post-first trimester abortions." *Id.* at 37a. The court then contended that the particular phrase "overt act" was also vague because it could "plausibly encompass a range of acts involved in non-intact D&E [abortions]," and that the phrase "does nothing to remedy the statute's failure to provide adequate notice of what forms of D&E the Act prohibits." *Id.* at 38a. Similarly, the court asserted that the phrase "living fetus" "adds to confusion about the scope of the prohibited conduct." *Id.* at 39a. Finally, the court concluded that any vagueness could not be cured by the Act's scienter requirements. *Ibid.*

b. The court of appeals further held, despite this Court's guidance in *Ayotte* v. *Planned Parenthood of Northern New England*, 126 S. Ct. 961 (2006), that the Act should be enjoined in its entirety. Pet. App. 40a-54a. The court of appeals initially suggested that, if the Act were facially invalid solely because it lacked a health exception, the court "might have been able to draft a more 'finely drawn' injunction." *Id.* at 41a (citation omitted). The court reasoned, however, that a narrower injunction would not be appropriate even in that instance, because such an injunction would be inconsistent with Congress's intent in promulgating the Act. *Ibid.* In the court's view, the Act's sponsors believed that the Act would have little force or effect if it contained a health exception. *Ibid.* Moreover, the court hypothesized that, "[p]articularly when an issue involving moral or religious values is at stake, it is far from true that the legislative body would always prefer some of a statute to none at all." *Id.* at 46a.

Ultimately, however, the court of appeals concluded that "we need not rest our decision as to the appropriate remedy

solely on the omission of a health exception" because the Act was also unconstitutional on other grounds. Pet. App. 47a. To remedy all of the asserted constitutional deficiencies, the court contended, it "would in effect have to strike the principal substantive provision that is now in the Act and then, akin to writing legislation, adopt new terms with new definitions and new language creating limitations on the Act's scope." *Ibid.* Such a remedy, the court reasoned, "would result in a statute that would be fundamentally different from the one enacted." *Ibid.* The court therefore concluded that the only appropriate remedy was to enjoin enforcement of the Act in its entirety. *Id.* at 54a.

SUMMARY OF ARGUMENT

The court of appeals erred in invalidating the Partial-Birth Abortion Ban Act of 2003. That Act is constitutional under this Court's precedents because it advances vital state interests in protecting human life and preventing a rarely used and gruesome late-term abortion procedure that resembles infanticide. At the same time, the Act does not deny any woman the ability to obtain a safe abortion using a more common abortion method, and thus imposes no undue burden on a woman's ability to obtain an abortion.

I. The absence of a health exception in the Act's ban on a particular abortion procedure does not amount to an undue burden. Under this Court's precedents, the relevant inquiry is whether a statute regulating an abortion procedure creates significant health risks, such that it places a substantial obstacle in the path of a woman seeking an abortion, in a large fraction of its applications. The court of appeals erred by reading *Stenberg* v. *Carhart*, 530 U.S. 914 (2000), as holding that the relevant inquiry is instead whether there is a *medical consensus* that *no circumstance exists* in which the procedure would be necessary to preserve a woman's health. Such a reading

would delegate authority over constitutional decisionmaking to a minority of medical professionals and put *Stenberg* into conflict with this Court's earlier decisions, including *Planned Parenthood of Southeastern Pennsylvania* v. *Casey*, 505 U.S. 833 (1992), which require a plaintiff to do more than merely demonstrate the existence of conflicting opinions about health risks in order to invalidate a statute. It would also create a conflict with this Court's decisions on the appropriate standard for facial challenges, which require a plaintiff to do more than merely demonstrate that a statute would be susceptible to unconstitutional application in *some* hypothetical situation. There is no reason for this Court to construe *Stenberg* in a manner that would *sub silentio* override its prior precedents.

Viewed in the proper light, the Act readily passes muster. In the Act, Congress made numerous factual findings concerning the medical necessity of partial-birth abortion, culminating in the ultimate finding that partial-birth abortion is *never* medically indicated to preserve the health of the mother. Those findings are supported by substantial evidence and are entitled to deference under long-standing principles. The court of appeals erred by failing to defer to Congress's ultimate and most relevant finding that partial-birth abortion is never medically necessary. Because that finding was supported both by the evidence before Congress and the testimony at trial in this case, it is entitled to deference.

Even apart from the deference owed to Congress, the evidence presented by respondents at trial at most suggests that partial-birth abortion may be *marginally* safer than more common abortion procedures in some hypothetical circumstances. Given the vital state interests in proscribing partial-birth abortion—a procedure that Congress found to be inhumane, bordering on infanticide, and subject to the most severe moral condemnation—such an attenuated interest does not give rise to an undue burden on a woman's access to an

abortion. That is particularly true since the statute denies no woman the ability to obtain a safe abortion through a more common abortion method. The court of appeals' contrary conclusion betrays a central premise of the joint opinion in *Casey*—namely, that the government retains a meaningful constitutional role in regulating abortion in order to protect human life and serve other important interests.

This Court's decision in *Stenberg* does not compel a different result. This case is distinguishable from *Stenberg* in several significant respects, and, as explained, under a proper reading of *Stenberg*, respondents' facial challenge to the constitutionality of the Act fails. To the extent that the Court concludes that *Stenberg* compels the conclusion that the Act is facially invalid, however, *Stenberg* should be overruled.

II. The Act readily passes muster under overbreadth and vagueness principles as well. Unlike the statute at issue in *Stenberg*, the Act does not reach standard D&E abortions, but instead is limited to abortions in which the physician delivers the fetus beyond a specified anatomical "landmark" and then performs a discrete "overt act" that kills the living fetus (and delivers the fetus with the purpose of performing that act). The Act therefore covers only abortions that constitute "partial-birth abortions" under any reasonable understanding of that concept. Nor is the Act void for vagueness, because it provides ample notice of the conduct that it prohibits and contains no ambiguous terms or phrases. In any event, because this case (unlike *Stenberg*) involves an Act of Congress, the solution to any overbreadth or vagueness problem that this Court believed to be lurking in the statute would be to adopt a narrowing construction of the Act, not to invalidate the Act on its face. The court of appeals erred in straining to find ambiguity, rather than construing the statute to avoid any infirmity.

III. Because the Act suffers from no constitutional defect, the Court need not fashion any remedy. If the Court nevertheless concludes that the Act is unconstitutional in any respect, however, it would be possible to craft narrower injunctive relief under *Ayotte* v. *Planned Parenthood of Northern New England*, 126 S. Ct. 961 (2006), depending on the exact nature of the Act's infirmity. Assuming that it were necessary to do so, a court could readily draft an injunction that would prevent the Act from being applied in any hypothetical situation in which a partial-birth abortion is medically required, or to any abortions other than partial-birth abortions. There is good reason to believe that Congress would have preferred a prohibition on partial-birth abortion which is judicially modified in that manner to no prohibition at all. In any event, because the statute is in fact facially constitutional, no remedial question arises in this case, and the judgment below should be reversed in its entirety.

ARGUMENT

THE PARTIAL-BIRTH ABORTION BAN ACT OF 2003 IS CONSTITUTIONAL ON ITS FACE

While the reasoning of the court of appeals here differs in some respects from that of the court of appeals in *Gonzales* v. *Carhart*, cert. granted, No. 05-380 (Feb. 21, 2006), it is equally flawed. In *Stenberg* v. *Carhart*, 530 U.S. 914 (2000), this Court held that a Nebraska statute banning "partial birth abortion" (as defined in that statute) was invalid for two independent reasons. First, the Court held that the statute was facially invalid because it lacked an exception for cases implicating the health of the mother. *Id.* at 930-938. Second, the Court held that the statute was invalid because it defined "partial birth abortion" in such a way as to reach not only D&X abortions, but also standard D&E abortions. *Id.* at 938-946.

The court of appeals in this case held that the federal Act was invalid on both of those grounds, and also because it contained language that it viewed as unconstitutionally vague. The court of appeals, however, consistently downplayed, or simply disregarded, the various respects in which the federal Act differs from the statute that was at issue in *Stenberg*. Most notably, the Act is accompanied by extensive congressional factual findings, to which deference is owed, on the medical necessity of partial-birth abortion; contains a more precise definition of the procedure it prohibits; and, as a federal statute, should be construed to ameliorate, rather than exacerbate, any constitutional difficulties. As in *Carhart*, those differences compel the conclusion that the Act is constitutional on its face.

I. THE ABSENCE OF A HEALTH EXCEPTION DOES NOT RENDER THE ACT FACIALLY INVALID

The court of appeals first held that the Partial-Birth Abortion Ban Act of 2003 was facially invalid because it lacked a health exception. That holding was based on the fallacious premise that a statute regulating an abortion procedure must contain a health exception unless there is a *medical consensus* that *no circumstance exists* in which the procedure would be necessary to preserve a woman's health. This Court's decisions, however, hold that such a statute is facially invalid only where, in a large fraction of its applications, it creates significant health risks, such that it imposes an undue burden by placing a substantial obstacle in the path of a woman seeking an abortion. In passing the Act, Congress found that the partial-birth abortion procedure at issue is *never* medically indicated to preserve the health of the mother. That finding is entitled to deference and is supported by substantial evidence, including evidence in the trial record in this case (as in *Carhart*). Moreover, even if partial-birth abortion had mar-

ginal health benefits in some cases, that still would not be sufficient to overcome Congress's compelling interests in protecting potential human life, drawing a bright line between abortion and infanticide, and prohibiting a rarely used, late-term abortion procedure that is inhumane.

A. A Statute That Regulates Abortion, But Lacks A Health Exception, Is Not Facially Invalid Unless It Would Create Significant Health Risks, And Thereby Impose An Undue Burden, In A Large Fraction Of Its Applications

1. The government's brief in *Carhart* explains (at 14-16) that, applying its earlier decisions in *Roe* v. *Wade*, 410 U.S. 113 (1973), and *Planned Parenthood of Southeastern Pennsylvania* v. *Casey*, 505 U.S. 833 (1992), this Court held in *Stenberg* that a statute prohibiting a particular abortion procedure without an express health exception would be unconstitutional if the statute would create "significant health risks"—*i.e.*, health risks significant enough to constitute an undue burden. 530 U.S. at 932; see *id.* at 931 (noting that "a State cannot subject women's health to significant risks"); *id.* at 938 (concluding that the statute at issue "creates a significant health risk"). The Court recognized that a statute prohibiting a particular abortion procedure would create significant health risks where the prohibited procedure is substantially safer than other procedures, either more generally or in specific circumstances (*e.g.*, where the mother has a particular health-threatening condition). *Id.* at 931. Applying that standard, the Court, pointing to the district court's findings and evidence, concluded that the plaintiff had demonstrated that the statute at issue would create significant health risks. *Id.* at 932; see *id.* at 934 (observing that the district court had found that "the D&X method was significantly *safer* in certain circumstances"); *id.* at 936 (noting the "District Court finding that D&X significantly obviates health risks in certain circum-

stances"). On that basis, the Court held the statute unconstitutional because it lacked a health exception. *Id.* at 938.

2. In this case, the court of appeals construed *Stenberg* as holding that "an abortion regulation that fails to contain a health exception is unconstitutional except when there is a *medical consensus* that *no circumstance exists* in which the procedure would be necessary to preserve a woman's health." Pet. App. 15a (emphases added). That analysis would give a handful of physicians veto power over the judgment of Congress (and a majority of the States) that partial-birth abortion should be proscribed, and is fundamentally mistaken.

a. In *Stenberg*, the Court did not hold that it would be sufficient for a plaintiff merely to point to the existence of conflicting evidence as to whether the statute at issue would create significant health risks. As the government's brief in *Carhart* demonstrates (at 16-18), although some language in the Court's opinion in *Stenberg* could be read, in isolation, to support that proposition, the Court ultimately made clear that it was not suggesting that "a State is prohibited from proscribing an abortion procedure whenever a particular physician deems the procedure preferable." 530 U.S. at 938. Moreover, such a reading of *Stenberg* would effectively put that decision into conflict with the Court's earlier decision in *Casey*, which in no way indicated that the relevant constitutional inquiry was whether there was any division of medical opinion on the existence of health risks. See 505 U.S. at 880.

The court of appeals in this case went even further than the court of appeals in *Carhart* by suggesting that a plaintiff need merely show the *absence of a consensus* that the statute at issue *would not* present significant health risks (rather than at least requiring the plaintiff to identify *substantial authority* for the proposition that the statute *would* in fact present significant health risks). Although the court of appeals in this case did state at one point that, "[b]y medical

consensus, we do not mean unanimity or that no single doctor disagrees," Pet. App. 15a, it nonetheless implied that a plaintiff could meet this requirement even where the overwhelming weight of authority showed that prohibiting a procedure would not present significant health risks. Nothing in this Court's opinion in *Stenberg* indicates that a small minority of physicians can effectively dictate the constitutionality of an abortion statute. The relevant constitutional inquiry cannot turn on the existence (or absence) of a "consensus."[1]

b. The court of appeals' interpretation of *Stenberg* is mistaken in another respect. The court of appeals construed *Stenberg* as holding that the relevant constitutional inquiry is whether "there is a medical consensus that *no circumstance exists*" in which the statute at issue would present significant health risks. Pet. App. 15a (emphasis added). In so reading *Stenberg*, the court of appeals injected an erroneous conception of facial challenges into its view of the relevant substantive test. Generally, a plaintiff mounting a facial challenge to a statute must show that there is no set of circumstances in which the statute can constitutionally be applied. See, *e.g.*, *United States* v. *Salerno*, 481 U.S. 739, 745 (1987). While the joint opinion in *Casey* appears to have relaxed the facial-challenge standard at least in the context of spousal-notification provisions, see U.S. Br. at 16-18, *Ayotte* v. *Planned Parenthood of N. New England*, 126 S. Ct. 961 (2006) (No. 04-1144), the court of appeals here appears to have suggested that a plaintiff need identify only *one* circumstance in which there is no consensus concerning the health benefits of the restricted

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[1] The court of appeals' opinion could even be read to require the *government* to prove the *existence* of a consensus that the statute would not present significant health risks, rather than requiring the *plaintiff* to prove the *absence* of such a consensus. So read, the court of appeals' opinion would reverse the general rule that the plaintiff bears the burden of proof in a facial challenge. See, *e.g.*, *United States* v. *Salerno*, 481 U.S. 739, 745 (1987).

procedure. Pet. App. 13a; see *id.* at 22a n.14. That misstates both the facial-challenge standard and the substantive standard. *Ayotte* makes clear that, whatever the appropriate standard for facial challenges, a statute should not be enjoined in all of its applications simply because it lacks an adequate health exception in some circumstances. See 126 S. Ct. at 969. Moreover, under the joint opinion in *Casey*, it is clear that the appropriate standard for judging the constitutionality of abortion statutes is whether the statute imposes an "undue burden" on a woman's access to an abortion.

The practical effect of the court of appeals' erroneous standard is that, at least with regard to a claim that an abortion statute would create impermissible health risks, there is no meaningful distinction between as-applied and facial challenges. Under the court of appeals' test, a plaintiff with no ability to demonstrate that the statute at issue would present significant risks to *her* health (and thus impose an "undue burden" on *her* access to an abortion) could nevertheless prevail on her as-applied challenge (and, indeed, obtain wholesale facial invalidation of the statute) as long as she could demonstrate that *some hypothetical circumstance* exists in which the statute would present significant risks to another woman. Nothing in *Stenberg* suggests that the Court intended to create such a radical exception to the ordinary rule that, in order to prevail on an as-applied challenge, the plaintiff must show that she would suffer injury from the statute being challenged. To the contrary, this Court has repeatedly upheld applications of abortion regulations to particular plaintiffs while still recognizing the potential for other, unconstitutional applications. See, *e.g.*, *Ohio* v. *Akron Ctr. for Reprod. Health*, 497 U.S. 502, 514 (1990); *Simopoulos* v. *Virginia*, 462 U.S. 506, 510 (1983); *H.L.* v. *Matheson*, 450 U.S. 398, 405-407 (1981); *Connecticut* v. *Menillo*, 423 U.S. 9, 11 (1975) (per curiam).

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To the extent that the court of appeals suggested that it would be sufficient to show that the statute would create significant health risks for even a single woman, such a rule would create a virtual presumption of facial invalidity and would eliminate in the abortion context any vestige of the traditional rules of standing (insofar as a plaintiff could effectively bring a facial challenge on behalf of another woman). Instead, the correct reading of *Stenberg* is that a statute that regulates a particular abortion procedure but lacks a health exception is not facially invalid unless, at a minimum, the statute would create significant health risks in a large fraction of its applications.[2]

B. When Analyzed Under The Proper Standard, The Record Overwhelmingly Supports Congress's Judgment That No Health Exception Was Required

In enacting the Partial-Birth Abortion Ban Act of 2003, Congress made numerous findings concerning the medical necessity of partial-birth abortion. The court of appeals in this case assumed, without deciding, that Congress's factual findings were entitled to deference, but concluded that Congress's threshold finding that a medical consensus exists that partial-birth abortion is never medically necessary was not supported by substantial evidence. That was error. Congress's factual findings were in fact entitled to deference, and substantial evidence supported Congress's ultimate and most relevant finding that partial-birth abortion is *never* medically indicated to preserve the health of the mother. The absence of a health exception therefore does not render the Act unconstitutional on its face.

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[2] Because the Act is clearly constitutional under the "large fraction" test, neither the instant case nor *Carhart* provides an appropriate vehicle to resolve whether the "no set of circumstances" standard from *Salerno* or the "large fraction" standard from *Casey* applies in this context. See 05-380 Br. 18-20.

1. Congressional Findings On Constitutionally Relevant Factual Issues Are Entitled To Great Deference

As the government's brief in *Carhart* explains (at 21-23), this Court has consistently held that courts should afford a high degree of deference to congressional factual findings that inform the constitutionality of federal statutes. See, *e.g.*, *Turner Broad. Sys., Inc.* v. *FCC*, 520 U.S. 180, 195 (1997) (*Turner II*). The Court has deferred to congressional findings in a wide variety of contexts—including findings in cases involving fundamental constitutional rights and heightened levels of scrutiny, see, *e.g.*, *id.* at 185, 189-190, and findings on complex medical or scientific issues, see, *e.g.*, *Jones* v. *United States*, 463 U.S. 354, 363-366 & n.13 (1983); *Lambert* v. *Yellowley*, 272 U.S. 581, 588-597 (1926); see also *Stenberg*, 530 U.S. at 964-972 (Kennedy, J., dissenting) (discussing cases); cf. *Kansas* v. *Hendricks*, 521 U.S. 346, 360 n.3 (1997) (noting that "it is precisely where * * * disagreement [among medical experts] exists that legislatures have been afforded the widest latitude in drafting * * * statutes").

Although the court of appeals recognized that, "[i]n some cases, the Court has expressly applied the substantial evidence standard described in *Turner* and related decisions," the court contended that, "[i]n others, the Court * * * has reviewed congressional findings of fact with considerably less deference." Pet. App. 18a. The two cases cited by the court of appeals for the latter proposition, however, do not support it. In both of those cases, this Court did not hold that the congressional findings at issue were subject to a lesser degree of deference, but instead held that those findings (even if valid) were simply insufficient, as a matter of law, to sustain a statute's constitutionality. See *Board of Trustees of the Univ. of Ala.* v. *Garrett*, 531 U.S. 356, 368 (2001) (noting, in holding that Congress did not validly abrogate the States'

Eleventh Amendment immunity in Title I of the Americans with Disabilities Act (ADA), that "[t]he legislative record of the ADA * * * simply fails to show that Congress did in fact identify a pattern of irrational state discrimination in employment against the disabled"); *United States* v. *Morrison*, 529 U.S. 598, 614 (2000) (noting, in holding that Congress lacked authority to enact the Violence Against Women Act under the Commerce Clause, that Congress's findings concerning the impact of sexually motivated violence failed to demonstrate a sufficient effect on interstate commerce).

The court of appeals therefore erred to the extent that it suggested that "no single standard exists" for deferring to congressional findings that bear on the constitutionality of statutes. Pet. App. 19a. There is a single standard. That standard is the one set out in *Turner II*, and the court of appeals erred in failing to defer to the relevant congressional findings.

2. *Congress's Findings On The Medical Necessity Of Partial-Birth Abortion Are Entitled To Deference*

In *Carhart*, the court of appeals concluded that "the government's argument regarding * * * deference [to congressional findings] is irrelevant to the case at hand," 05-380 Pet. App. 15a, on the ground that *Stenberg* somehow foreclosed Congress from making factual findings on the medical necessity of partial-birth abortion, see *id.* at 16a-20a. In this case, by contrast, the court of appeals concluded that Congress's findings on the medical necessity of partial-birth abortion were entitled to at least some respect—and thereby implicitly acknowledged that *Stenberg* did not foreclose Congress from making its own findings on that issue. See, *e.g.*, Pet. App. 16a (stating that, "[u]nder the constitutional rule established in *Stenberg* * * *, we must inquire whether—applying the appropriate degree of deference to the legislative body's find-

ings—the legislature properly concluded that there is *consensus in the medical community* that the banned procedure is never medically necessary to preserve the health of women").

For the reasons stated in the government's brief in *Carhart* (at 26-30), the court of appeals was correct to recognize that deference was owed to congressional findings relevant to the legal test identified in *Stenberg*. The problem with the court of appeals' analysis is that it misidentified both the legal test applied in *Stenberg* and the relevant congressional finding. The correct test and critical finding focus not on the presence (or absence) of medical consensus, but rather on the necessity (or lack thereof) of the restricted procedure for the health of the mother.

3. *Congress's Findings On The Medical Necessity Of Partial-Birth Abortion Are Supported By Substantial Evidence*

Based on its misreading of *Stenberg*, the court of appeals in this case simply asked the wrong question: namely, whether substantial evidence supported the proposition that there is a *medical consensus* that no circumstance exists in which the procedure would be necessary to preserve a woman's health. Pet. App. 15a. The relevant question under *Stenberg* is instead whether substantial evidence supported Congress's ultimate finding that "partial-birth abortion is never medically indicated to preserve the health of the mother." Act § 2(14)(O), 117 Stat. 1206. Because substantial evidence plainly supported that finding, it is entitled to deference.

a. In engaging in "substantial evidence" review, a reviewing court should not "reweigh the evidence *de novo*, or * * * replace Congress' factual predictions with [its] own." *Turner II*, 520 U.S. at 211 (citation omitted). Instead, a reviewing court is required to defer to a congressional finding even if

the "evidence is in conflict." *Ibid.*; see *id.* at 208, 210. Although a reviewing court may consider not only the evidence that was before Congress, but also any evidence adduced at trial, in engaging in "substantial evidence" review, *id.* at 195, 212, the critical inquiry is whether there is sufficient evidence to suggest that *Congress's* determination was reasonable—not whether the reviewing court would reach the same determination as Congress on the basis of the record that Congress had before it (as supplemented by any evidence adduced at trial). See, *e.g.*, *id.* at 210-211; *Rostker* v. *Goldberg*, 453 U.S. 57, 82-83 (1981).

b. Substantial evidence supported Congress's ultimate finding that partial-birth abortion is never necessary to preserve the mother's health.

i. As the government's brief in *Carhart* sets out in greater detail (at 31-35), the record that Congress had before it strongly supported Congress's findings concerning the medical necessity of partial-birth abortion. Most of the physicians who appeared before Congress testified in favor of the Act. Those physicians testified that there were no circumstances in which a partial-birth abortion was the only appropriate type of abortion; that partial-birth abortion offers no safety advantages over other types of abortion; and that partial-birth abortion itself presents various safety risks that other abortion procedures do not. In addition to the testimony of those physicians, other evidence in the legislative record—including statements from leading physician groups, articles in medical journals, and written statements from other physicians—supported Congress's findings. Indeed, in making its findings, Congress expressly credited the conclusion of the American Medical Association (AMA) that partial-birth abortion is "never the only appropriate [abortion] procedure." Act § 2(14)(C), 117 Stat. 1204 (citation omitted).

ii. At trial in this case, as in *Carhart*, still other physicians testified that partial-birth abortion was never medically necessary, thereby confirming the reasonableness of Congress's findings.[3] To summarize, Dr. Watson Bowes, a professor emeritus of obstetrics and gynecology at the University of North Carolina specializing in maternal-fetal medicine, testified that medical studies had failed to show that partial-birth abortion offered any safety advantages over other types of abortion. J.A. 545-553, 564-568.

Dr. Steven Clark, a professor of obstetrics and gynecology at the University of Utah and ACOG fellow specializing in maternal-fetal medicine, testified that, in his experience, he had "never encountered a situation where either medical induction or D&E didn't work." He further testified that there is no "basis for using D&X," because D&E is a "well-studied alternative" that is "incredibly safe" and "incredibly effective." J.A. 864-865, 877, 890-892, 895-896.[4]

Dr. Curtis Cook, an assistant professor of medicine at Michigan State University and ACOG fellow specializing in maternal-fetal medicine, testified that he "[did not] believe that [partial-birth abortion] is ever medically necessary." He explained that "there are other methods that are available, safer, well-established methods." And he concluded that he had "grave concerns" that "elements of the [partial-birth abortion] procedure have risks for both immediate complications and long-term complications." J.A. 774-776.

Dr. Charles Lockwood, chairman of the department of obstetrics and gynecology at Yale University and a specialist in maternal-fetal medicine, testified that there is no evidence

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[3] Many of the same physicians testified in both cases—and some of the testimony in this case was actually incorporated into the record in *Carhart*. See, *e.g.*, 05-380 J.A. 510-563, 622-691, 823-869.

[4] The district court appears to have ignored Dr. Clark's testimony altogether. See Pet. App. 100a-101a.

that "the D&X offers advantages over medical terminations and D&Es." He added that he "cannot conceive of a circumstance where an intact D&X is the only option for terminating a pregnancy," because there are "very reasonable" alternative abortion methods. Notably, he so testified despite the fact that he supported abortion rights and personally opposed the Act. J.A. 990, 994, 1001, 1011, 1025-1026, 1039.

Dr. Elizabeth Shadigian, an associate professor of obstetrics and gynecology at the University of Michigan and ACOG fellow, testified that she had "never personally had to use a partial-birth abortion procedure to take care of women, even sick women with medical conditions." She stated that "there is no sound basis to say there is anything safe about the D&X procedure, especially when there are other procedures * * * that are safe and well-studied in the medical literature." J.A. 678-687, 707-710.

Finally, Dr. LeRoy Sprang, an ACOG fellow, testified that he had "never seen a situation where an intact D&X was necessary," and that, in emergency situations, a partial-birth abortion "would never be the only choice and never be the best choice." He added that partial-birth abortion "presents serious safety risk to the mother." J.A. 600-606, 653-654, 666-667.

c. To be sure, respondents did present some evidence at trial suggesting that partial-birth abortion may be marginally safer than other types of abortion in certain hypothetical circumstances (*e.g.*, where the mother has preeclampsia or placenta previa) or as a more categorical matter (*e.g.*, because a partial-birth abortion requires fewer instrument insertions in the uterus than a standard D&E abortion).[5] After reviewing

[5] As in *Carhart*, respondents relied heavily at trial on a peer-review study led by Dr. Stephen Chasen, a plaintiff in other litigation challenging the constitutionality of the Act. For the reasons stated in the government's brief in *Carhart* (at 37 n.12), however, that study does not support the proposition

the evidence presented at trial, moreover, the district court did find that "intact D&E is in fact the safest medical option for some women in some circumstances," though it failed to specify what those circumstances were (and also found that "plaintiffs have not demonstrated the existence of any particular situation * * * in which an intact D&E would be a doctor's *only* option to preserve the life or health of a woman"). Pet. App. 147a (emphasis added).

But any adverse trial evidence or findings by the district court, even if more clearly focused on the relevant legal question (*viz.*, the existence of significant health risks in a large fraction of the statute's applications), would not necessarily imply that Congress's factual findings are invalid. See, *e.g.*, *Turner II*, 520 U.S. at 210-211; *Rostker*, 453 U.S. at 82-83. Indeed, to the extent that the lower courts were correct in finding a lack of "consensus" concerning the medical necessity of partial-birth abortion, see Pet. App. 22a, 215a, the necessary implication is that, at a minimum, there is substantial evidence to support Congress's conclusion that partial-birth abortion is never medically indicated. A contrary standard would permit a single district court judge to override the considered judgment of Congress simply by finding that there is *some* room for disagreement on an issue of medical fact.

At various points in its opinion, the district court seemingly suggested that deference to Congress's factual findings was inappropriate because the government's witnesses at trial (and the witnesses who testified in favor of the Act before Congress) were not credible. As a preliminary matter, deference to congressional factfinding presumably entails, at a minimum, leaving judgments about the credibility of congressional witnesses to Congress, which actually heard those wit-

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that partial-birth abortion is ever medically necessary to preserve a mother's health. Indeed, the district court ultimately conceded that the study "cannot be considered conclusive on the issue." Pet. App. 143a.

nesses. Cf., *e.g.*, *Akins* v. *Texas*, 325 U.S. 398, 401 (1945) (noting that reviewing court owes deference to credibility determinations by "the trier of fact who heard the witnesses in full and observed their demeanor on the stand"). In any event, the district court identified no valid rationale for questioning the credibility of the witnesses who testified in favor of the Act, either at trial or before Congress.

The district court correctly noted that the physicians who testified that partial-birth abortion was never medically necessary did not carry out partial-birth abortions themselves. See, *e.g.*, Pet. App. 100a (noting that "none [of the government's expert witnesses] had performed the intact D&E procedure at issue in this case"); *id.* at 198a (further noting that, "[l]ike the government's witnesses in this case, none of the six physicians who testified before Congress had ever performed an intact D&E"). It is hardly surprising, however, that physicians who testified under oath that partial-birth abortion was never medically necessary would *not* carry out such abortions. Many of those physicians, moreover, were maternal-fetal experts who specialized in treating women with high-risk pregnancies (including women who had suffered complications from abortions)—and who were therefore perfectly capable of assessing the risks that would attend partial-birth abortions, as the district court to some extent acknowledged. See *id.* at 104a (finding that the government's witnesses were "eminently qualified as obgyn practitioners" and permitting their testimony "regarding their opinions on the safety of the procedure, based upon their review of the literature").

The district court also noted that many of the doctors who testified that partial-birth abortion was never medically necessary were opposed to abortion more generally. See, *e.g.*, Pet. App. 199a. That is not true of all of the government's witnesses. For example, Dr. Lockwood testified that he supported abortion rights (and personally opposed the Act). See

J.A. 1001, 1039. In any event, a physician's opposition to abortion more generally does not prevent him from objectively evaluating the comparative risks presented by different abortion *methods*. In addition, the record reflects that many of the witnesses who testified that partial-birth abortion was medically necessary themselves opposed the Act (and other abortion regulations). See, *e.g.*, Creinin Tr. 733 (testimony of respondents' witness, Dr. Mitchell Creinin, that he does "not think it is appropriate for Congress to legislate at all about the abortion procedure that physicians can and cannot perform pre-viability"). The district court nevertheless did not treat those witnesses' apparent support for abortion as undermining their credibility. Such disparate treatment was unjustified. Because there is no legitimate basis for questioning the evidence supporting Congress's findings on the medical necessity of partial-birth abortion, including its ultimate and most relevant finding that partial-birth abortion is never medically indicated to preserve the mother's health, those findings are valid and entitled to deference.

C. A Statute That Prohibits Partial-Birth Abortion Does Not Impose An Undue Burden On A Woman's Access To An Abortion, And *Stenberg* Should Be Overruled To The Extent That It Compels A Different Result

1. Finally, even if the Court refused to defer to Congress's considered findings, respondents' trial evidence at most suggested that partial-birth abortion is *marginally* safer than other safe abortion procedures in certain rare circumstances. Absent a showing that it would "create *significant* health risks," however, a statute prohibiting partial-birth abortion does not impose an undue burden on a woman's access to an abortion. *Stenberg*, 530 U.S. at 932 (emphasis added). A different understanding would all but remove the government's compelling interest in protecting potential hu-

man life from the equation in reviewing abortion regulations, and thus depart from one of the central teachings of *Casey*. See *Stenberg*, 530 U.S. at 967 (Kennedy, J., dissenting) (stating that, "[w]here the difference in physical safety is, at best, marginal, the State may take into account the grave moral issues presented by a new abortion method") (citing *Casey*, 505 U.S. at 880).

In adopting the undue-burden standard (and thereby relaxing the standard for reviewing abortion regulations that had emerged from the Court's post-*Roe* decisions), the joint opinion in *Casey* emphasized that the government has a "profound interest in potential life," 505 U.S. at 878, and that the Court's prior cases had undervalued that "profound interest" in analyzing the constitutionality of abortion statutes, see *id.* at 871. As the government's brief in *Carhart* explains (at 40-43), the Act implicates not only the government's compelling interest in protecting human life, but also the government's specific (and no less compelling) interest in prohibiting a particular type of abortion procedure that closely resembles infanticide. The gravity of those interests is beyond question. See *Stenberg*, 530 U.S. at 963 (Kennedy, J., dissenting) (noting that partial-birth abortion has been "subject to the most severe moral condemnation, condemnation reserved for the most repulsive human conduct"); *id.* at 979 (describing partial-birth abortion as "a procedure many decent and civilized people find so abhorrent as to be among the most serious of crimes against human life"). In light of the relative strength of the government's interests in prohibiting partial-birth abortion, and the relative weakness of a woman's interest in having access to a particular type of abortion procedure that has no health advantages (according to Congress), or at most marginal health advantages, when compared with other, unregulated types of procedures, the Act is constitutional

under *Casey* because it does not impose an undue burden on a woman's access to an abortion.

If the joint opinion in *Casey* does not leave room for the government to proscribe a rarely used, grotesque, and inhumane late-term procedure such as partial-birth abortion, which at best could offer only marginal health benefits in a tiny category of hypothetical cases, it is difficult to see how the joint opinion accomplished its stated objective of elevating the government's "important and legitimate interest in potential life" in the equation, and thus establishing a more "appropriate means of reconciling the [government's] interest with the woman's constitutionally protected liberty." 505 U.S. at 871, 876 (citation omitted). Indeed, if such a procedure is unconstitutional under the *Casey* framework, it is difficult to see how any meaningful late-term abortion regulation could survive scrutiny.

2. As explained in the government's brief in *Carhart* (at 43), the Court's decision in *Stenberg* is distinguishable in a number of important respects from this case. Most notably, the statute at issue here is an Act of Congress accompanied by congressional findings that are amply supported by substantial evidence and therefore entitled to deference. In addition, the statute carefully defines partial-birth abortion so that it does not reach the more common D&E procedure. Moreover, because this case involves a federal statute, the federal courts have much greater latitude to interpret the statute to avoid any constitutional difficulties. And the trial record in this case is much more extensive than the trial record in *Stenberg*, where the trial lasted only one day (whereas the trial in this case lasted almost three weeks, and the trial in *Carhart* lasted two weeks).

If, however, the Court were to conclude for any reason that *Stenberg* compels the conclusion that the Act is unconstitutional, *Stenberg* should be overruled for the reasons given

in the government's brief in *Carhart* (at 43-44). Indeed, as discussed above, a reading of *Stenberg* that requires invalidation of the Act would put *Stenberg* into conflict with the earlier decisions on which it was purportedly based, including *Casey*. The better view, however, is that *Stenberg*, as properly understood, does not support the conclusion that the Act is facially invalid because it lacks a health exception.

II. THE ACT IS NEITHER UNCONSTITUTIONALLY OVERBROAD NOR UNCONSTITUTIONALLY VAGUE

The court of appeals in this case, unlike the court of appeals in *Carhart*, went on to hold that the Act was facially invalid because it was unconstitutionally overbroad, Pet. App. 23a-33a, and because it was unconstitutionally vague, *id.* at 33a-40a. Each of those additional holdings is erroneous.

A. The Act Is Not Unconstitutionally Overbroad

1. In *Stenberg*, this Court held that the Nebraska statute at issue was invalid not only because it lacked a health exception, but also because it defined "partial birth abortion" in such a way as to reach standard D&E abortions as well as D&X abortions, and thereby imposed an undue burden on a woman's access to an abortion. 530 U.S. at 938-946. That statute barred a physician from "deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child." Neb. Rev. Stat. Ann. § 28-326(9) (Supp. 1999). The Court explained that a standard D&E abortion "will often involve a physician pulling a 'substantial portion' of a still living fetus, say, an arm or leg, into the vagina prior to the death of the fetus." 530 U.S. at 939. The Court thus reasoned that, "[e]ven if the statute's basic aim is to ban D&X, its language makes clear that it also covers a much broader category of procedures." *Ibid.* The Court further explained

that the Nebraska statute did not "anywhere suggest that its application turns on whether a portion of the fetus' body is drawn into the vagina as part of a process to extract an intact fetus after collapsing the head as opposed to a process that would dismember the fetus." *Ibid.* "The plain language of the statute," the Court concluded, "covers both procedures." *Ibid.*

2. The statute at issue here contains a definition of "partial-birth abortion" which differs in two critical respects from the statutory definition at issue in *Stenberg*. First, the Act applies only where the person performing the abortion "deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother." Act § 3, 117 Stat. 1206-1207 (18 U.S.C. 1531(b)(1) (Supp. III 2003)). Unlike the Nebraska statute, the Act thus specifies so-called anatomical "landmarks" beyond which the fetus must be delivered in order to trigger the Act's application. Second, the Act applies only where the person performing the abortion also "performs [an] overt act, other than completion of delivery, that kills the partially delivered living fetus," and delivers the fetus with the purpose of performing that overt act. *Ibid.* Unlike the Nebraska statute, the Act thus requires the performance of a discrete "overt act," wholly apart from delivery of the specified portion of the fetus.

3. Despite those differences, the court of appeals concluded that the Act was unconstitutionally overbroad because it "covers non-intact as well as intact D&Es." Pet. App. 30a. That conclusion is incorrect. In a standard D&E abortion, the physician dismembers the fetus while the remainder of the fetus is still inside the womb—typically by grasping the nearest body part and then tearing it off. J.A. 144-147, 452. The

Act plainly excludes such abortions. Because the Act specifies anatomical "landmarks" beyond which the fetus must be delivered, the Act excludes any standard D&E abortion in which a smaller portion of the fetus, such as a foot or arm, is drawn through the cervix (or outside the mother's body altogether), and torn from the fetus, while the fetus is still living. Moreover, because the Act specifies that the physician must perform a discrete "overt act, other than the completion of delivery," the Act excludes any standard D&E abortion not already excluded by the anatomical "landmark" requirement, because, in a standard D&E abortion, the "delivery" of a portion of the fetus is incidental and integral to (and thus indistinguishable from) the performance of the lethal act (*i.e.*, the dismemberment of the fetus). When considered in conjunction, therefore, the various requirements of the Act operate to exclude standard D&E abortions.

Respondents did present some evidence at trial suggesting that physicians who intend to perform standard D&E abortions are occasionally able to remove the fetus either entirely or largely intact, typically because the mother's cervix is more fully dilated. See Pet. App. 66a-67a. The Act, however, applies only where the person performing the abortion has the specific intent, at the outset of the procedure, to deliver the requisite portion of the fetus for the purpose of performing the ultimate lethal act. See Act § 3, 117 Stat. 1206-1207 (18 U.S.C. 1531(b)(1) (Supp. III 2003)). Even assuming that it could be said that a physician in such a case intends at the outset to deliver the requisite portion of the fetus, but see Pet. App. 66a (noting that "[t]he potential for a largely intact removal cannot be ascertained until the surgical procedure has already begun"), it cannot be said that the physician specifically intends at the outset to deliver the requisite portion of the fetus *for the purpose of performing the ultimate lethal act*, as the Act requires. Thus, in the highly un-

usual situation in which a physician can show that he set out to perform a standard D&E abortion but ultimately had to perform a partial-birth abortion (for example, because the physician unintentionally delivered the requisite portion of the fetus), the Act would be inapplicable. Respondents therefore cannot identify any circumstance in which the Act would cover a physician intending to perform a standard D&E abortion.

Although the court of appeals concluded that the Act "covers non-intact as well as intact D&Es," Pet. App. 30a, the only alleged example of the former given by the court of appeals was an abortion in which a physician delivers the requisite portion of the fetus and only then performs a discrete act of dismemberment. See, *e.g.*, *id.* at 29a-30a, 31a-32a. As a preliminary matter, the court of appeals cited no authority except an amicus brief for the proposition that physicians ever intentionally perform abortions in this manner, and the record in this case (as well as the record before Congress) contains no evidence supporting that proposition. See *id.* at 31a-32a. Rather, the record suggests that physicians performing abortion generally either use the cervix to restrain the body of the fetus to enable dismemberment (in performing a standard D&E abortion) or deliver the fetus beyond a specified anatomical "landmark" for the purpose of subsequently killing the living fetus by crushing the fetal skull (in performing a D&X or intact D&E abortion). The record does not suggest that physicians partially deliver the fetus beyond a specified anatomical "landmark" for the purpose of subsequently killing the living fetus *by dismemberment*. In any event, such an abortion would merely constitute an especially gruesome form of the partial-birth abortion procedure that the Act seeks to outlaw. Because there is no sense in which a delivery-followed-by-dismemberment abortion can be classified as a standard D&E abortion, the very premise of the court of ap-

peals' overbreadth analysis—that the Act covers some non-intact D&E abortions—is simply incorrect.

4. The court of appeals in this case asserted that, "[w]hen drafting the Act * * *, Congress deliberately chose not to follow the Court's guidance" in *Stenberg* concerning "how to draft a statute that would adequately distinguish between the two forms of D&E." Pet. App. 24a, 25a. In *Stenberg*, however, the Court indicated that the critical question was whether the statute "track[s] the medical differences" between partial-birth abortion and other, more common types of abortion. 530 U.S. at 939. For the reasons discussed above, and contrary to the court of appeals' conclusion (see Pet. App. 25a), the Act does track the medical differences between partial-birth abortions and standard D&E abortions, by defining the prohibited procedure in a way that excludes the latter.[6]

The court of appeals' real complaint is that Congress failed to provide an *express exception* for standard D&E abortions. See, *e.g.*, Pet. App. 24a-25a.[7] In *Stenberg*, however, the Court made clear that including such an exception was only an "example" of how a legislature could draw a permissible statute regulating partial-birth abortion, not a categorical requirement. See 530 U.S. at 939. In light of the Act's detailed definition of the prohibited procedure, Congress could reasonably have concluded that an express exception for standard

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[6] Moreover, the Act's definitional approach has the advantage of prohibiting particular forms of abortion (such as the court of appeals' hypothetical delivery-followed-by-dismemberment abortion) that might not strictly qualify as "D&X abortions," but are clearly partial-birth abortions of the type that Congress sought to prohibit.

[7] The Act does effectively contain an express exception for *induction* abortions—*i.e.*, abortions that are accomplished through the "completion of delivery" of a living (but non-viable) fetus. See Act § 3, 117 Stat. 1207 (18 U.S.C. 1531(b)(1)(B) (Supp. III 2003)).

D&E abortions would have been superfluous.[8] Nor is it clear that even an express exception would address all the overbreadth concerns identified by the court of appeals. Such an exception, for example, would presumably not be sufficient to exclude abortions involving unintended partial delivery (absent a purpose requirement of the type contained in the Act), nor would it presumably be sufficient to exclude the hypothetical delivery-followed-by-dismemberment abortions cited by the court of appeals (which, for the reasons stated above, do not constitute standard D&E abortions at all). In the end, it is clear that the court of appeals effectively held Congress to impossible standards of draftsmanship. Because *Stenberg* required a legislature seeking to regulate partial-birth abortion only to define the prohibited procedure with sufficient particularity to exclude other, more common types of abortion, and because the Act readily meets that requirement, the Act is not unconstitutionally overbroad.

5. Finally, to the extent that there is any doubt as to whether the Act reaches standard D&E abortions as well as D&X abortions, the Court should interpret the Act to exempt all standard D&E abortions and thus to avoid any constitutional difficulties. Indeed, because this case involves a federal statute, the Court has a much greater capacity to interpret the statute to avoid constitutional difficulties than it did in

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[8] Both the majority opinion and Justice O'Connor's concurring opinion in *Stenberg* favorably cited a Kansas statute that contains an express exception. See 530 U.S. at 939; *id.* at 950 (O'Connor, J., concurring). That statute excludes, *inter alia*, "the * * * dilation and evacuation abortion procedure involving dismemberment of the fetus *prior to removal* from the body of the pregnant woman." Kan. Stat. Ann. § 65-6721(b)(2) (West Supp. 1998) (emphasis added). For the reasons explained above, however, the federal Act already defines the prohibited procedure in such a way as to exclude abortions that would fall within that statutory exception (and that statutory exception clearly would not exclude the court of appeals' hypothetical delivery-followed-by-dismemberment abortion).

Stenberg. See, *e.g.*, *Webb* v. *Webb*, 451 U.S. 493, 500 (1981); *Gooding* v. *Wilson*, 405 U.S. 518, 520 (1972); *United States* v. *Thirty-Seven Photographs*, 402 U.S. 363, 369-370 (1971); cf. *Stenberg*, 530 U.S. at 944-945. If this Court were to conclude that there is any constitutional infirmity with regard to the breadth of the Act, the solution would be to interpret the Act to avoid such infirmity and not, as the court of appeals seemingly did, to construe the statute to exacerbate any infirmity and then invalidate the Act in its entirety.

B. The Act Is Not Unconstitutionally Vague

1. In order to survive a vagueness challenge, a statute must "give the person of ordinary intelligence a reasonable opportunity to know what is prohibited, so that he may act accordingly." *Grayned* v. *City of Rockford*, 408 U.S. 104, 108 (1972). The Constitution, however, does not impose "impossible standards of clarity," *Kolender* v. *Lawson*, 461 U.S. 352, 361 (1983) (internal quotation marks and citation omitted), nor does it require "mathematical certainty" from statutory language, *Grayned*, 408 U.S. at 110. Instead, a statute is not vague if it is "clear what the [statute] as a whole prohibits." *Ibid*. Moreover, "speculation about possible vagueness in hypothetical situations not before the Court will not support a facial attack on a statute when it is surely valid in the vast majority of its intended applications." *Hill* v. *Colorado*, 530 U.S. 703, 733 (2000) (internal quotation marks and citation omitted). Finally, in the context of a federal statute, federal courts have broad authority to construe the statute to provide clarity and to avoid unconstitutional vagueness. See, *e.g.*, *Dennis* v. *United States*, 341 U.S. 494, 501-502 (1951).

2. The court of appeals held both that the operative provisions of the Act more generally were unconstitutionally vague, see Pet. App. 34a-35a, 37a, and that specific phrases within the Act were also unconstitutionally vague, see *id*. at

38a-39a. Because the Act readily satisfies the relatively modest requirements of the void-for-vagueness doctrine, each of those holdings is erroneous.

a. The court of appeals suggested that the Act's operational provisions were vague "when read as a whole" because the Act "could readily be applied to a range of methods of performing post-first trimester abortions." Pet. App. 37a, 40a. As a preliminary matter, the court of appeals' conclusion that the Act was vague because it *might* cover standard D&E abortions is in some tension with its earlier conclusion that the Act was overbroad because it *does* cover standard D&E abortions—as the court of appeals itself recognized. See, *e.g.*, *id.* at 34a. Indeed, the only way to reconcile those two observations is to conclude that the court of appeals flouted its normal obligation to construe terms it deems vague in such a way as to avoid, rather than exacerbate, any constitutional difficulty. See *Thornburgh* v. *American Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 829 (1986) (O'Connor, J., dissenting) (criticizing majority for "invent[ing] an unprecedented canon of construction under which in cases involving abortion, a permissible reading of a statute is to be avoided at all costs") (internal quotation marks and citation omitted).

In any event, the Act's operational provisions are neither vague nor overbroad, because the Act unambiguously excludes standard D&E abortions (and, *a fortiori*, could reasonably be so construed), and otherwise precisely defines the conduct that it prohibits. See pp. 30-36, *supra*. As discussed above, the Act prohibits only a particular type of abortion in which the physician "deliberately and intentionally vaginally delivers a living fetus" up to a specific anatomical point "outside the body of the mother"; does so "for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus"; and then "performs the overt act, other than completion of delivery, that kills the partially

delivered living fetus." Act § 3, 117 Stat. 1206-1207 (18 U.S.C. 1531(b)(1) (Supp. III 2003)). In addition, the physician must "knowingly" perform that type of abortion. § 3, 117 Stat. 1206 (18 U.S.C. 1531(a) (Supp. III 2003)). Neither the court of appeals nor respondents suggest how Congress could have defined the proscribed conduct any more precisely—and it is hard to imagine how it would be possible to do so, at least while still reaching the full range of conduct that Congress legitimately aimed to prohibit.

b. The court of appeals also suggested that the specific phrases "overt act" and "living fetus" were vague. See Pet. App. 38a-39a.[9] With regard to the phrase "overt act," the court of appeals reasoned that the phrase, even as limited by the phrase "other than completion of delivery," could "plausibly encompass a range of acts involved in non-intact D&E" and therefore "does nothing to remedy the statute's failure to provide adequate notice of what forms of D&E the Act prohibits." *Id.* at 38a. But, as is true with any statutory phrase, the phrase "overt act" must be read in context. See, *e.g.*, *Hibbs* v. *Winn*, 542 U.S. 88, 101 (2004); *General Dynamics Land Sys., Inc.* v. *Cline*, 540 U.S. 581, 596 (2004); *Jones* v. *United States*, 527 U.S. 373, 389 (1999). And when read in context, the phrase "overt act" obviously refers to an act that is distinct from the act of partial delivery (thereby excluding standard D&E abortions, in which the act of "delivery" is incidental and integral to the act of dismemberment). Any breadth in that phrase is necessary to prevent a physician from evading the prohibition on partial-birth abortions simply by performing an atypical lethal act. Moreover, it does not follow from the fact that the phrase "overt act" is in some respects *broad* that the

[9] For its part, the district court appears to have concluded that the phrase "partial-birth abortion" was also vague. See Pet. App. 92a-93a. That phrase, however, is expressly defined in the Act, and, for the reasons discussed in text, none of the terms or phrases used *within* that definition is ambiguous.

phrase is also *vague*. See, *e.g.*, *Pennsylvania Dep't of Corr.* v. *Yeskey*, 524 U.S. 206, 209-212 (1998). To the contrary, as the district court in *Carhart* noted, the phrase "overt act" is a "standard statutory term[] of art," 05-380 Pet. App. 529a, which appears in numerous other criminal statutes. See, *e.g.*, 18 U.S.C. 1117, 1201(c), 2101(a).

As for the phrase "living fetus," the court of appeals reasoned that "the use of the term 'living fetus' instead of 'viable fetus' creates additional confusion about the Act's scope." Pet. App. 39a. The natural inference, however, is that Congress deliberately chose to use the phrase "living fetus," rather than "viable fetus," precisely because it wanted to reach abortions that occurred late in the term but prior to viability. And, as the court of appeals acknowledged (before inexplicably reaching a contradictory conclusion), the phrase "living fetus" does in fact have a specific meaning: *i.e.*, a fetus that "has a detectable heartbeat or pulsating umbilical cord." *Ibid.*; see 05-380 Pet. App. 529a (concluding that the term "living" is a "commonplace word" of which "doctors have a practical understanding"). Like the phrase "overt act," therefore, the phrase "living fetus" may be broad in some respects, but it is not vague. In sum, because the Act contains no ambiguous terms and phrases, and because the Act as a whole plainly provides sufficient notice of the conduct it prohibits, the court of appeals erred by holding the Act void for vagueness.

3. Finally, to the extent that the Court were to conclude that the Act is unconstitutionally vague in any respect, it could readily give that federal statute a narrowing construction—just as it could if it were to conclude that the Act is unconstitutionally overbroad. See pp. 35-36, *supra*. In that respect, this case fundamentally differs from *Stenberg*, in which this Court was less free to give the statute at issue a narrowing construction to avoid any constitutional infirmity because

of the Court's more limited capacity so to construe state statutes.

III. THE COURT OF APPEALS' REMEDIAL ANALYSIS IS FUNDAMENTALLY FLAWED

The court of appeals held that the Act should be enjoined in its entirety. Pet. App. 40a-54a. Of course, if this Court concludes that the court of appeals erred on the merits, it would not need to reach the question of the appropriate remedy. If, however, this Court were to identify some respect in which the Act is invalid, it would be possible, and thus presumptively appropriate, to craft narrower injunctive relief along the lines suggested in *Ayotte* v. *Planned Parenthood of Northern New England*, 126 S. Ct. 961 (2006), depending on the exact nature of the Act's infirmity. Because the Act is in fact facially valid, further development of the remedial question identified in *Ayotte* will have to await another case. At a minimum, however, it is clear that the court of appeals' approach to the remedial question was fundamentally flawed.

A. In *Ayotte*, the Court considered a facial challenge to the constitutionality of a New Hampshire parental-notification statute that did not contain an express statutory exception for cases in which a medical emergency required an immediate abortion. 126 S. Ct. at 964-965. New Hampshire conceded the possibility of applications of the statute in emergency situations which could create significant health risks and that "it would be unconstitutional to apply [the statute] in a manner that subjects minors" to such risks. *Id.* at 967.

In light of that concession, the Court "turn[ed] to the question of remedy." *Ayotte*, 126 S. Ct. at 967. The Court reasoned that "[t]hree interrelated principles inform our approach to remedies." *Ibid.* First, the Court stated that "we try not to nullify more of a legislature's work than is necessary"; thus, the Court noted, the "normal rule" is that "par-

tial, rather than facial, invalidation is the required course." *Id.* at 967-968 (citation omitted). Second, the Court explained that, "mindful that our constitutional mandate and institutional competence are limited, we restrain ourselves from rewrit[ing] state law to conform it to constitutional requirements even as we try to salvage it." *Id.* at 968 (internal quotation marks and citation omitted). Third, the Court suggested that "the touchstone for any decision about remedy is legislative intent, for a court cannot use its remedial powers to circumvent the intent of the legislature." *Ibid.* (internal quotation marks and citation omitted).[10] Under that principle, the Court added, the relevant inquiry, "[a]fter finding an application or portion of a statute unconstitutional," is whether "the legislature [would] have preferred what is left of its statute to no statute at all." *Ibid.* The Court thus vacated the court of appeals' decision invalidating the statute in its entirety and remanded for a determination as to whether a narrower injunction, prohibiting only the statute's "few" unconstitutional applications, could be crafted consistent with legislative intent. *Id.* at 969.

B. 1. The court of appeals in this case initially suggested that, if the Act were facially invalid solely because it lacked a health exception, the court "might have been able to draft a more 'finely drawn' injunction" under *Ayotte*. Pet. App. 41a (citation omitted). The court ultimately concluded, however, that a narrower injunction would not be appropriate even in that instance, because such an injunction would be inconsistent with Congress's intent in promulgating the Act. *Ibid.*

That conclusion is erroneous. In reaching that conclusion, the court of appeals heavily relied on the fact that "Congress did not inadvertently omit a health exception from the Act."

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[10] Obviously, to the extent that federalism concerns inform those limits on judicial competence, such concerns are inapplicable in the context of a federal statute.

Pet. App. 42a. It is certainly true that Congress considered, and ultimately rejected, various proposals to include an express health exception in the Act. In doing so, various members expressed concern that a statutory health exception would be abused by physicians who would claim that an elective partial-birth abortion was nevertheless necessary to preserve the mother's health. See, *e.g.*, H.R. Rep. No. 58, 108th Cong., 1st Sess. 69 (2003) (statement of Rep. Chabot) (stating that "a health exception, no matter how narrowly drafted, gives the abortionist unfettered discretion in determining when a partial-birth abortion may be performed"); 149 Cong. Rec. H4940 (daily ed. June 4, 2003) (statement of Rep. Sensenbrenner) (contending that "[a]bortionists have demonstrated that they can and will justify any abortion on the grounds that it, in the judgment of the attending physician, is necessary to avert serious adverse health consequences to the woman"); 149 Cong. Rec. S3607 (daily ed. Mar. 12, 2003) (statement of Sen. Santorum) (asserting that, "[i]n practice, of course, health means anything, so there is no restriction at all"); 143 Cong. Rec. 8355 (1997) (statement of Sen. Hutchinson) (noting that health exception "would allow any abortionist to kill a baby even after viability merely by signing a permission slip to himself, a so-called certification").[11]

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[11] Evidence before Congress demonstrated that Congress's concern was a very real one. For example, in Kansas—described by one legislator as "the partial-birth abortion capital of the nation," see Scott Rothschild, *Abortions on the Rise, State Reports*, Wichita Eagle, Mar. 25, 2000, at 1A—the State Department of Health reported that 182 partial-birth abortions were conducted in 1999. In every one of those 182 abortions, the physician certified that the abortion was necessary to prevent a "mental," rather than "physical," impairment of the mother. See 05-380 Pet. App. 108a-109a; cf. *Stenberg*, 530 U.S. at 972 (Kennedy, J., dissenting) ("A ban which depends on the 'appropriate medical judgment' of Dr. Carhart is no ban at all. * * * This, of course, is the vice of a health exception resting in the physician's discretion.").

It does not necessarily follow from the fact that Congress purposefullly adopted a statute *without* a health exception rather than a statute *with* a health exception, however, that Congress would have preferred *no statute at all* to a statute with a (judicially crafted) health exception—the relevant inquiry under *Ayotte*. See 126 S. Ct. at 968. Congress specifically found that partial-birth abortion was a "gruesome," "brutal," and "inhumane" procedure, Act §§ 2(1), 2(14)(L), 2(14)(N), 117 Stat. 1201, 1206, which raised serious ethical and medical concerns, *e.g.*,§§ 2(1), 2(14)(A), 2(14)(J), 117 Stat. 1201, 1204, 1205. Those findings, and the statements of various members, suggest that the proponents of the Act would have preferred to prohibit partial-birth abortions in at least some circumstances, even if they could not have prohibited them altogether. See, *e.g.*, *Partial-Birth Abortion—The Truth: Joint Hearing Before the Senate Comm. on the Judiciary and the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 105th Cong., 1st Sess. 97 (1997) (statement of Sen. Ashcroft) (asserting that, "if there were one young child that was subjected to this procedure needlessly, I think it would be incumbent upon all of us * * * to cry out against it").[12]

The court of appeals hypothesized that, "[p]articularly when an issue involving moral or religious values is at stake, it is far from true that the legislative body would always prefer some of a statute to none at all," on the ground that "the leaders of the battle * * * may conclude that leaving an

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[12] Moreover, to the extent that the absence of a health exception would impose an undue burden only in specific circumstances (*e.g.*, where the mother suffers from a particular health-threatening condition or conditions), the partial invalidation of the statute (*e.g.*, as applied to women with specific conditions) would leave much of the statute intact and thus would not lead to the circumvention concerns that apparently motivated proponents of the Act to omit a health exception in the first place.

issue completely unaddressed will make it easier for them to achieve their ultimate goals than would a partial resolution that leaves their 'base' discontented and disillusioned." Pet. App. 46a. Based on that hypothesis, the court concluded that "[w]hether the congressional partisans who supported the Act would have preferred" some statute to no statute at all "is a determination we are simply unable and unwilling to make." *Id.* at 47a. But the fact that the *Ayotte* analysis is counterfactual (and thus difficult) is not an excuse for failing to undertake that analysis, let alone for adopting a rule that, where the intent of Congress is not obvious, a court should err on the side of facial invalidation. After all, the Court reiterated in *Ayotte* that partial, rather than facial, invalidation was the "normal rule." 126 S. Ct. at 968 (citation omitted). Accordingly, if the court of appeals were "unable" to find that Congress would have preferred *no* statute to a modified statute, it should have opted for partial invalidation instead.

In the end, any difficulty that the court of appeals faced in crafting a narrower injunction in this case may have stemmed from its erroneous analysis of the merits. On the merits, the court of appeals concluded that "a substantial disagreement exists in the medical community regarding whether [the] procedures [banned by the Act] are necessary in certain circumstances." Pet. App. 22a, but failed to identify the specific "circumstances" to which it was referring (*i.e.*, the particular health-threatening condition or conditions that it believed would necessitate a partial-birth abortion).[13] The court of appeals' difficulty in fashioning a narrower remedy can thus be traced to the deficiencies in plaintiffs' evidence and the court's resulting inability to elaborate on the basis for its holding that

[13] The court of appeals' inability to do so is not surprising, since the district court specifically found that "plaintiffs have not demonstrated the existence of any particular situation * * * in which an intact D&E would be a doctor's only option to preserve the life or health of a woman." Pet. App. 147a.

the Act was facially invalid in the first place. If this Court were to conclude that any such circumstances existed (despite Congress's findings to the contrary), it could readily enjoin the Act's application in those specific circumstances while leaving the remainder of the Act intact.

2. The court of appeals in this case concluded that, if the Act were also facially invalid because it was unconstitutionally overbroad and vague, it would be inappropriate to craft narrower injunctive relief. Pet. App. 47a-54a. That conclusion is doubly mistaken. To begin with, any potential overbreadth or vagueness concerns with a federal statute could and should be addressed in the first instance by adopting a narrowing construction of the statute. In any event, if the Court ultimately concluded that the Act could only be construed such that it either *does* cover some standard D&E abortions (and thus is unconstitutionally overbroad) or *might* cover some standard D&E abortions (and thus is unconstitutionally vague), a narrower injunction could easily be crafted to prevent the Act from being applied to those abortions while permitting it to be applied to partial-birth abortions.

The court of appeals identified two primary reasons for concluding that narrower injunctive relief would be inappropriate. First, the court of appeals stated that crafting narrower injunctive relief "would require us to make decisions that are the prerogative of elected officials" and, "akin to writing legislation, adopt new terms with new definitions and new language creating limitations on the Act's scope." Pet. App. 47a. But concerns about usurping a legislative function do not provide an excuse for declining to engage in the *Ayotte* analysis or applying the "normal rule" favoring partial invalidation. Nor is this a case in which a court would need to make any legislative or policy judgments in crafting narrower injunctive relief. It is clear from Congress's findings, and from statements of proponents and opponents alike in the legisla-

tive record, that Congress's purpose in passing the Act was to prohibit partial-birth abortions, not standard D&E abortions (or any other abortions). See, *e.g.*, Act §§ 2(1), 2(2), 2(14)(A)-(O), 117 Stat. 1201, 1204-1206; *Partial-Birth Abortion Ban Act of 1995: Hearing Before the Senate Comm. on the Judiciary*, 104th Cong., 1st Sess. 1 (1995) (statement of Sen. Hatch); *id.* at 14 (statement of Sen. Kennedy); *Partial-Birth Abortion Ban Act of 2002: Hearing Before the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 107th Cong., 2d Sess. 2 (2002) (statement of Rep. Chabot). Any overbreadth or vagueness resulting from the fact that the Act either clearly or arguably prohibits other types of abortion could thus be cured, consistent with legislative intent, simply by clarifying that the Act does not reach standard D&E abortions (and thereby limiting the Act's reach to partial-birth abortions).[14]

Second, the court of appeals asserted that "the magnitude of the change in the Act's coverage that would be necessary * * * would result in a statute that would be fundamentally different from the one enacted." Pet. App. 47a. There is no basis, however, for the court of appeals' suggestion that a narrower injunction "would leave us with an Act of a drastically more limited scope" that "would outlaw only a very small portion of the procedures prohibited under the existing Act."

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[14] Remarkably, the court of appeals suggested that it would be inappropriate to craft an injunction that limited the Act to partial-birth abortions because it was uncertain whether even a statute that prohibited only partial-birth abortion would be constitutionally valid. Pet. App. 49a; see *id.* at 26a n.18, 47a. It is clear, however, that at least a majority of the Court (if not the entire Court) in *Stenberg* believed, at a minimum, that "a ban on partial birth abortion that only proscribed the D&X method of abortion and that included an exception to preserve the life and health of the mother would be constitutional." 530 U.S. at 951 (O'Connor, J., concurring); see *id.* at 979 (Kennedy, J., joined by Rehnquist, C.J., dissenting); *id.* at 1020 (Thomas, J., joined by Rehnquist, C.J., and Scalia, J., dissenting).

Id. at 50a, 51a. While that might be true if the Act reached not only partial-birth abortions, but also *all* standard D&E abortions (which are much more common), the court of appeals did not explain how the Act could be so read. In fact, the only alleged example of a standard D&E abortion given by the court of appeals was an abortion in which a physician delivers the requisite portion of the fetus and only then performs a discrete act of dismemberment. Such an abortion is not properly classified as a standard D&E abortion at all, see pp. 33-34, *supra*, nor is there any evidence that physicians ever intentionally perform abortions in that manner. Accordingly, even if there were any difficulty with the statute reaching such hypothetical abortions, the resulting overbreadth or vagueness in the Act would affect at most a small fraction of its applications, if any, and narrower injunctive relief would not result in a "drastically limited" or "fundamentally different" statute.

C. In any event, as in *Carhart*, there is no need for the Court to reach any remedial issue in this case. Here, Congress has proscribed a single, rarely used late-term abortion procedure that it found to be both medically unnecessary and inhumane. Upholding the Act merely requires the Court to reaffirm the government's critical interests in regulating abortion procedures to protect human life and to prohibit procedures that blur the line between abortion and infanticide.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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AUGUST 2006

APPENDIX

UNITED STATES PUBLIC LAWS
108th Congress - First Session
Convening January 7, 2003

PL 108-105 (S 3)
Nov. 5, 2003

PARTIAL-BIRTH ABORTION BAN ACT OF 2003

An Act To prohibit the procedure commonly known as partial-birth abortion.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SEC. 1. SHORT TITLE.

This Act may be cited as the "Partial-Birth Abortion Ban Act of 2003".

SEC. 2. FINDINGS.

The Congress finds and declares the following:

(1) A moral, medical, and ethical consensus exists that the practice of performing a partial-birth abortion—an abortion in which a physician deliberately and intentionally vaginally delivers a living, unborn child's body until either the entire baby's head is outside the body of the mother, or any part of the baby's trunk past the navel is outside the body of the mother and only the head remains inside the womb, for the purpose of performing an overt act (usually the puncturing of the back of the child's skull and removing the baby's brains) that the person knows will kill the partially delivered infant, performs this act, and then completes delivery of the dead infant—is a gruesome and inhumane procedure that is never medically necessary and should be prohibited.

(2) Rather than being an abortion procedure that is embraced by the medical community, particularly among physicians who routinely perform other abortion procedures, partial-birth abortion remains a disfavored procedure that is not only unnecessary to preserve the health of the mother, but in fact poses serious risks to the long-term health of women and in some circumstances, their lives. As a result, at least 27 States banned the procedure as did the United States Congress which voted to ban the procedure during the 104th, 105th, and 106th Congresses.

(3) In Stenberg v. Carhart, 530 U.S. 914, 932 (2000), the United States Supreme Court opined "that significant medical authority supports the proposition that in some circumstances, [partial birth abortion] would be the safest procedure" for pregnant women who wish to undergo an abortion. Thus, the Court struck down the State of Nebraska's ban on partial-birth abortion procedures, concluding that it placed an "undue burden" on women seeking abortions because it failed to include an exception for partial-birth abortions deemed necessary to preserve the "health" of the mother.

(4) In reaching this conclusion, the Court deferred to the Federal district court's factual findings that the partial-birth abortion procedure was statistically and medically as safe as, and in many circumstances safer than, alternative abortion procedures.

(5) However, substantial evidence presented at the Stenberg trial and overwhelming evidence presented and compiled at extensive congressional hearings, much of which was compiled after the district court hearing in Stenberg, and thus not included in the Stenberg trial record, demonstrates that a partial-birth abortion is never necessary to preserve the health of a woman, poses significant health

risks to a woman upon whom the procedure is performed and is outside the standard of medical care.

(6) Despite the dearth of evidence in the Stenberg trial court record supporting the district court's findings, the United States Court of Appeals for the Eighth Circuit and the Supreme Court refused to set aside the district court's factual findings because, under the applicable standard of appellate review, they were not "clearly erroneous". A finding of fact is clearly erroneous "when although there is evidence to support it, the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake has been committed". Anderson v. City of Bessemer City, North Carolina, 470 U.S. 564, 573 (1985). Under this standard, "if the district court's account of the evidence is plausible in light of the record viewed in its entirety, the court of appeals may not reverse it even though convinced that had it been sitting as the trier of fact, it would have weighed the evidence differently". Id. at 574.

(7) Thus, in Stenberg, the United States Supreme Court was required to accept the very questionable findings issued by the district court judge—the effect of which was to render null and void [illegible] reasoned factual findings and policy determinations of the United States Congress and at least 27 State legislatures.

(8) However, under well-settled Supreme Court jurisprudence, the United States Congress is not bound to accept the same factual findings that the Supreme Court was bound to accept in Stenberg under the "clearly erroneous" standard. Rather, the United States Congress is entitled to reach its own factual findings—findings that the Supreme Court accords great deference—and to enact legislation based upon these findings so long as it seeks to pursue a legitimate interest that is within the scope of the

Constitution, and draws reasonable inferences based upon substantial evidence.

(9) In Katzenbach v. Morgan, 384 U.S. 641 (1966), the Supreme Court articulated its highly deferential review of congressional factual findings when it addressed the constitutionality of section 4(e) of the Voting Rights Act of 1965. Regarding Congress' factual determination that section 4(e) would assist the Puerto Rican community in "gaining nondiscriminatory treatment in public services," the Court stated that "[i]t was for Congress, as the branch that made this judgment, to assess and weigh the various conflicting considerations * * *. It is not for us to review the congressional resolution of these factors. It is enough that we be able to perceive a basis upon which the Congress might resolve the conflict as it did. There plainly was such a basis to support section 4(e) in the application in question in this case.". Id. at 653.

(10) Katzenbach's highly deferential review of Congress' factual conclusions was relied upon by the United States District Court for the District of Columbia when it upheld the "bail-out" provisions of the Voting Rights Act of 1965 (42 U.S.C. 1973c), stating that "congressional fact finding, to which we are inclined to pay great deference, strengthens the inference that, in those jurisdictions covered by the Act, state actions discriminatory in effect are discriminatory in purpose". City of Rome, Georgia v. U.S., 472 F. Supp. 221 (D.D.C. 1979) aff'd City of Rome, Georgia v. U.S., 446 U.S. 156 (1980).

(11) The Court continued its practice of deferring to congressional factual findings in reviewing the constitutionality of the must-carry provisions of the Cable Television Consumer Protection and Competition Act of 1992. See Turner Broadcasting System, Inc. v. Federal Communications Commission, 512 U.S. 622 (1994) (Turner I)

and Turner Broadcasting System, Inc. v. Federal Communications Commission, 520 U.S. 180 (1997) (Turner II). At issue in the Turner cases was Congress' legislative finding that, absent mandatory carriage rules, the continued viability of local broadcast television would be "seriously jeopardized". The Turner I Court recognized that as an institution, "Congress is far better equipped than the judiciary to 'amass and evaluate the vast amounts of data' bearing upon an issue as complex and dynamic as that presented here", 512 U.S. at 665-66. Although the Court recognized that "the deference afforded to legislative findings does 'not foreclose our independent judgment of the facts bearing on an issue of constitutional law,'" its "obligation to exercise independent judgment when First Amendment rights are implicated is not a license to reweigh the evidence de novo, or to replace Congress' factual predictions with our own. Rather, it is to assure that, in formulating its judgments, Congress has drawn reasonable inferences based on substantial evidence.". Id. at 666.

(12) Three years later in Turner II, the Court upheld the "must-carry" provisions based upon Congress' findings, stating the Court's "sole obligation is 'to assure that, in formulating its judgments, Congress has drawn reasonable inferences based on substantial evidence.'" 520 U.S. at 195. Citing its ruling in Turner I, the Court reiterated that "[w]e owe Congress' findings deference in part because the institution 'is far better equipped than the judiciary to "amass and evaluate the vast amounts of data" bearing upon' legislative questions," id. at 195, and added that it "owe[d] Congress" findings an additional measure of deference out of respect for its authority to exercise the legislative power.". Id. at 196.

(13) There exists substantial record evidence upon which Congress has reached its conclusion that a ban on partial-

birth abortion is not required to contain a "health" exception, because the facts indicate that a partial-birth abortion is never necessary to preserve the health of a woman, poses serious risks to a woman's health, and lies outside the standard of medical care. Congress was informed by extensive hearings held during the 104th, 105th, 107th, and 108th Congresses and passed a ban on partial-birth abortion in the 104th, 105th, and 106th Congresses. These findings reflect the very informed judgment of the Congress that a partial-birth abortion is never necessary to preserve the health of a woman, poses serious risks to a woman's health, and lies outside the standard of medical care, and should, therefore, be banned.

(14) Pursuant to the testimony received during extensive legislative hearings during the 104th, 105th, 107th, and 108th Congresses, Congress finds and declares that:

(A) Partial-birth abortion poses serious risks to the health of a woman undergoing the procedure. Those risks include, among other things: An increase in a woman's risk of suffering from cervical incompetence, a result of cervical dilation making it difficult or impossible for a woman to successfully carry a subsequent pregnancy to term; an increased risk of uterine rupture, abruption, amniotic fluid embolus, and trauma to the uterus as a result of converting the child to a footling breech position, a procedure which, according to a leading obstetrics textbook, "there are very few, if any, indications for * * * other than for delivery of a second twin"; and a risk of lacerations and secondary hemorrhaging due to the doctor blindly forcing a sharp instrument into the base of the unborn child's skull while he or she is lodged in the birth canal, an act which could result in severe bleeding, brings with it the threat of shock, and could ultimately result in maternal death.

(B) There is no credible medical evidence that partial-birth abortions are safe or are safer than other abortion procedures. No controlled studies of partial-birth abortions have been conducted nor have any comparative studies been conducted to demonstrate its safety and efficacy compared to other abortion methods. Furthermore, there have been no articles published in peer-reviewed journals that establish that partial-birth abortions are superior in any way to established abortion procedures. Indeed, unlike other more commonly used abortion procedures, there are currently no medical schools that provide instruction on abortions that include the instruction in partial-birth abortions in their curriculum.

(C) A prominent medical association has concluded that partial-birth abortion is "not an accepted medical practice", that it has "never been subject to even a minimal amount of the normal medical practice development," that "the relative advantages and disadvantages of the procedure in specific circumstances remain unknown," and that "there is no consensus among obstetricians about its use". The association has further noted that partial-birth abortion is broadly disfavored by both medical experts and the public, is "ethically wrong," and "is never the only appropriate procedure".

(D) Neither the plaintiff in Stenberg v. Carhart, nor the experts who testified on his behalf, have identified a single circumstance during which a partial-birth abortion was necessary to preserve the health of a woman.

(E) The physician credited with developing the partial-birth abortion procedure has testified that he has never encountered a situation where a partial-birth abortion was medically necessary to achieve the desired outcome and, thus, is never medically necessary to preserve the health of a woman.

(F) A ban on the partial-birth abortion procedure will therefore advance the health interests of pregnant women seeking to terminate a pregnancy.

(G) In light of this overwhelming evidence, Congress and the States have a compelling interest in prohibiting partial-birth abortions. In addition to promoting maternal health, such a prohibition will draw a bright line that clearly distinguishes abortion and infanticide, that preserves the integrity of the medical profession, and promotes respect for human life.

(H) Based upon Roe v. Wade, 410 U.S. 113 (1973) and Planned Parenthood v. Casey, 505 U.S. 833 (1992), a governmental interest in protecting the life of a child during the delivery process arises by virtue of the fact that during a partial-birth abortion, labor is induced and the birth process has begun. This distinction was recognized in Roe when the Court noted, without comment, that the Texas parturition statute, which prohibited one from killing a child "in a state of being born and before actual birth," was not under attack. This interest becomes compelling as the child emerges from the maternal body. A child that is completely born is a full, legal person entitled to constitutional protections afforded a "person" under the United States Constitution. Partial-birth abortions involve the killing of a child that is in the process, in fact mere inches away from, becoming a "person". Thus, the government has a heightened interest in protecting the life of the partially-born child.

(I) This, too, has not gone unnoticed in the medical community, where a prominent medical association has recognized that partial-birth abortions are "ethically different from other destructive abortion techniques because the fetus, normally twenty weeks or longer in gestation, is killed outside of the womb". According to this medical association, the "partial birth" gives the fetus an autonomy

which separates it from the right of the woman to choose treatments for her own body".

(J) Partial-birth abortion also confuses the medical, legal, and ethical duties of physicians to preserve and promote life, as the physician acts directly against the physical life of a child, whom he or she had just delivered, all but the head, out of the womb, in order to end that life. Partial-birth abortion thus appropriates the terminology and techniques used by obstetricians in the delivery of living children—obstetricians who preserve and protect the life of the mother and the child—and instead uses those techniques to end the life of the partially-born child.

(K) Thus, by aborting a child in the manner that purposefully seeks to kill the child after he or she has begun the process of birth, partial-birth abortion undermines the public's perception of the appropriate role of a physician during the delivery process, and perverts a process during which life is brought into the world, in order to destroy a partially-born child.

(L) The gruesome and inhumane nature of the partial-birth abortion procedure and its disturbing similarity to the killing of a newborn infant promotes a complete disregard for infant human life that can only be countered by a prohibition of the procedure.

(M) The vast majority of babies killed during partial-birth abortions are alive until the end of the procedure. It is a medical fact, however, that unborn infants at this stage can feel pain when subjected to painful stimuli and that their perception of this pain is even more intense than that of newborn infants and older children when subjected to the same stimuli. Thus, during a partial-birth abortion procedure, the child will fully experience the pain associated

with piercing his or her skull and sucking out his or her brain.

(N) Implicitly approving such a brutal and inhumane procedure by choosing not to prohibit it will further coarsen society to the humanity of not only newborns, but all vulnerable and innocent human life, making it increasingly difficult to protect such life. Thus, Congress has a compelling interest in acting—indeed it must act—to prohibit this inhumane procedure.

(O) For these reasons, Congress finds that partial-birth abortion is never medically indicated to preserve the health of the mother; is in fact unrecognized as a valid abortion procedure by the mainstream medical community; poses additional health risks to the mother; blurs the line between abortion and infanticide in the killing of a partially-born child just inches from birth; and confuses the role of the physician in childbirth and should, therefore, be banned.

SEC. 3. PROHIBITION ON PARTIAL-BIRTH ABORTIONS.

(a) IN GENERAL.—Title 18, United States Code, is amended by inserting after chapter 73 the following:

"CHAPTER 74—PARTIAL-BIRTH ABORTIONS

"Sec.

"1531. Partial-birth abortions prohibited.

"§ 1531. Partial-birth abortions prohibited

"(a) Any physician who, in or affecting interstate or foreign commerce, knowingly performs a partial-birth abortion and thereby kills a human fetus shall be fined under this title or imprisoned not more than 2 years, or both. This subsection does not apply to a partial-birth abortion that is necessary to save the life of a mother whose life is

endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself. This subsection takes effect 1 day after the enactment.

"(b) As used in this section—

"(1) the term 'partial-birth abortion' means an abortion in which the person performing the abortion—

"(A) deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and

"(B) performs the overt act, other than completion of delivery, that kills the partially delivered living fetus; and

"(2) the term 'physician' means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the doctor performs such activity, or any other individual legally authorized by the State to perform abortions: Provided, however, That any individual who is not a physician or not otherwise legally authorized by the State to perform abortions, but who nevertheless directly performs a partial-birth abortion, shall be subject to the provisions of this section.

"(c)(1) The father, if married to the mother at the time she receives a partial-birth abortion procedure, and if the mother has not attained the age of 18 years at the time of the abortion, the maternal grandparents of the fetus, may in a civil action obtain appropriate relief, unless the pregnancy resulted from the plaintiff's criminal conduct or the plaintiff consented to the abortion.

"(2) Such relief shall include—

"(A) money damages for all injuries, psychological and physical, occasioned by the violation of this section; and

"(B) statutory damages equal to three times the cost of the partial-birth abortion.

"(d)(1) A defendant accused of an offense under this section may seek a hearing before the State Medical Board on whether the physician's conduct was necessary to save the life of the mother whose life was endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself.

"(2) The findings on that issue are admissible on that issue at the trial of the defendant. Upon a motion of the defendant, the court shall delay the beginning of the trial for not more than 30 days to permit such a hearing to take place.

"(e) A woman upon whom a partial-birth abortion is performed may not be prosecuted under this section, for a conspiracy to violate this section, or for an offense under section 2, 3, or 4 of this title based on a violation of this section.".

(b) CLERICAL AMENDMENT.—The table of chapters for part I of title 18, United States Code, is amended by inserting after the item relating to chapter 73 the following new item:

"74. Partial-birth abortions.....1531".

Approved November 5, 2003.

(4)

No. 05-1382

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OFFICE OF THE CLERK
SUPREME COURT, U.S.

In The
Supreme Court of the United States

ALBERTO R. GONZALES, ATTORNEY GENERAL,

Petitioner,

v.

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., ET AL.,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF OF THE CITY AND COUNTY OF SAN FRANCISCO IN RESPONSE TO THE PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether the Court of Appeals correctly held that the "Partial Birth Abortion Ban Act of 2003," Pub. L. No. 108-105, 117 Stat. 1201 (to be codified at 18 U.S.C. § 1531) ("Act"), is unconstitutional on its face because it effectively bans all forms of dilation and evacuation ("D&E") abortions, the most commonly used previability second-trimester abortion method, and therefore imposes an undue burden on a woman's right to end a previability pregnancy?

2. Whether the Court of Appeals correctly held that the Act is unconstitutionally vague because it fails to provide fair warning of the medical procedures it bans and permits arbitrary and discriminatory enforcement?

3. Whether the Court of Appeals correctly held that the Act is unconstitutional on its face, even if it is construed as banning only the intact variant of D&E abortion, because it bans such abortions even when they are safer for the woman?

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INTRODUCTION

The Court should grant plenary review of the Ninth Circuit's decision and schedule the case for argument with *Gonzales v. Carhart*, No. 05-380. In suggesting that the Court should merely hold the case for decision in *Carhart*, the government soft-pedals the differences between the two cases. In fact, the Ninth Circuit answered two significant constitutional questions that are predicates to the question presented in *Carhart*. The first is whether the Partial-Birth Abortion Ban Act imposes an undue burden on a patient's right to end a previability pregnancy by effectively banning all variants of dilation and evacuation ("D&E") abortions, as opposed to just "intact D&E" abortions.[1] The second is whether the Act is unconstitutionally vague because it does not make clear to physicians whether it bans all variants of D&E (not to mention inductions) or just intact D&E. If the answer to either of these questions is "yes," that is the end of the matter. Only if the answer to both questions is "no" must the Court reach the question presented in *Carhart* (and the third question presented in this case), namely, whether the absence of a health exception renders the Act unconstitutional.

Furthermore, the Ninth Circuit opinion is the only one to grapple with the proper scope of an injunction against

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[1] The courts below used the terms "intact D&E" and "non-intact D&E" rather than "D&X" and "D&E," respectively. As the Ninth Circuit stated, "[t]he labeling of the procedure is of no consequence to our analysis; however, for simplicity's sake we prefer intact and non-intact D&E. What is relevant, however, is that one could substitute D&X for intact D&E wherever the latter term appears in our opinion and nothing would change in any respect." Pet. App. 3a-4a & n.3. This brief uses the same terminology as the opinion below.

enforcement of the Partial-Birth Abortion Ban Act in light of *Ayotte v. Planned Parenthood of N. New England*, ___ U.S. ___, 126 S.Ct. 961 (2006). Should the Court agree that the Act is constitutionally defective, it will presumably wish to turn to this issue. Because the Eighth Circuit in *Carhart* did not have occasion to apply *Ayotte*, this case presents a much better vehicle for addressing the remedy question.

As all parties agree, these constitutional questions are not merely high-profile; they are also very important. Given their importance, the Court should review an appellate case that actually decided them. And instead of adopting the government's question presented, which does not adequately identify the issues decided by the Ninth Circuit, the Court should adopt the questions presented by the Respondents.[2]

STATEMENT

For the convenience of the Court, this Statement does not repeat the detailed discussion of the legal and factual background set forth in the briefs filed in connection with the Petition for Certiorari in *Carhart*. Rather, this Statement focuses on the aspects of the district court and Ninth Circuit opinions that demonstrate the benefits of plenary review of both *Carhart* and this case.

[2] The questions presented in this brief are identical to those contained in the brief of Respondents Planned Parenthood Federation of America and Planned Parenthood Golden Gate.

1. On November 6, 2003, Respondents Planned Parenthood Federation of America, Inc. and Planned Parenthood Golden Gate ("Planned Parenthood") filed suit in the Northern District of California, challenging the constitutionality of the Partial-Birth Abortion Ban Act of 2003 (the "Act"), Pub. L. No. 108-105, 117 Stat. 1201 (to be codified at 18 U.S.C. § 1531).[3] Respondent City and County of San Francisco ("CCSF" or "San Francisco") intervened as a plaintiff to protect the interests of its health providers who perform D&E and induction abortions and the largely low-income patient population served by those providers. After a three-week bench trial in which the parties presented the testimony of thirteen expert witnesses, the district court issued a ruling that described the evidence in detail, made extensive findings of fact, and permanently enjoined the government from enforcing the Act. Pet. App. 55a-218a.

2. The district court held that the Act suffers from three separate constitutional infirmities. First, after analyzing the expert testimony, it found that the Act has the practical effect of banning the same abortion procedures as the Nebraska statute struck down in *Stenberg v.*

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[3] The Act criminalizes the conduct of any doctor who:

> (A) deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and
>
> (B) performs the overt act, other than completion of delivery, that kills the partially delivered living fetus. . . .

18 U.S.C. § 1531(b)(1).

Carhart, 530 U.S. 914 (2000). Pet. App. 80a-85a. Among other things, the court made the factual finding that "[w]hen beginning a D&E . . . procedure, a physician cannot predict if the procedure will proceed in such a manner that it violates the Act, but the physician knows that is a possibility." Pet. App. 84a. Accordingly, "[p]hysicians may perform each element contained in the Act's definition in any D&E procedure . . . " *Id.* at 85a. "And, because D&E procedures comprise nearly 85-95% of all second trimester abortions, the Act creates a risk of criminal liability during virtually all abortions performed after the first trimester." *Id.* at 85a-86a.

Second, the district court held that the Act is unconstitutionally vague because physicians reading the Act "do not understand exactly what the Act prohibits." Pet. App. 92a. The court cited a number of flaws in the statutory language that, when considered in light of the trial testimony, contribute to the Act's vagueness. *Id.* at 92a-93a (finding, among other things, that the term "partial-birth abortion" has "little if any medical significance" among practitioners, that the term " 'overt act' may be interpreted to comprise many acts, performed not only in the process of an intact D&E, but in the course of a D&E by disarticulation or induction as well. . . .", and that use of the term "living fetus" adds to the vagueness of the Act).

Third, the court turned to the health exception issue. It stated that although it had already found the Act unconstitutional on undue burden and vagueness grounds, it would also address the plaintiffs' health exception argument "given the time and resources expended by the parties and this court, and the extensive evidence presented on the issue. . . ." *Id.* at 96a. And the court found that, even if the Act could somehow be construed as only

banning intact D&E's in a manner that was not unduly vague, it would still be unconstitutional for failure to include a health exception. *Id.* at 213a-217a.

3. The Ninth Circuit affirmed. Pet. App. 1a-54a. It agreed that the Act imposes an undue burden because, just like the Nebraska statute struck down in *Stenberg*, it bans both intact and non-intact D&E's. Pet. App. 26a-33a. The court noted that although "the *Stenberg* Court provided legislatures with guidance about how to draft statutes that would adequately distinguish between the two forms of D&E," either by expressly stating that the statute regulates only intact D&E's or by tracking the medical differences between the two procedures, "Congress deliberately chose not to follow the Court's guidance." *Id.* at 24a-25a (citing *Stenberg*, 530 U.S. at 939, and 530 U.S. at 950 (O'Connor, J., concurring)). Instead, "Congress defined the prohibited procedure in a way that a number of doctors have explained includes both intact and non-intact D&E's, and that we likewise conclude bans both forms of the procedure." Pet. App. 25a-26a.

The court also agreed with the district court that the Act is unconstitutionally vague. It made clear that even if a colorable argument could be made that the Act extends only to intact D&E's, physicians who set out to perform non-intact D&E's "have good reason to fear that they will be deemed subject to [the Act's] prohibitions," because the terms of the Act "could readily be applied to a range of methods of performing post-first trimester abortions." *Id.* at 37a.

The court also found, as the Eighth Circuit did in *Carhart*, that the absence of a health exception rendered the Act unconstitutional under *Stenberg*:

> In reviewing the Act's lack of a health exception, the dispositive question is not, as the government asserts, whether Congress's finding that the prohibited procedures are never necessary to preserve the health of a mother offers a reasonable (or plausible) resolution of a genuine factual dispute (which incidentally the record shows it does not). Rather, under *Stenberg*, it is whether there is general agreement in the medical community that there are no circumstances in which the procedure would be necessary to preserve a woman's health.
>
> Even the most cursory review of the Act and the congressional record developed in support of it reveals that no such medical consensus exists, a fact that the government essentially concedes in its brief to this court and that is fully confirmed by the evidence introduced in the district court during trial.

Pet. App. 21a-22a.

Finally, the court addressed the question of how to remedy the Act's constitutional defects in light of this Court's recent decision in *Ayotte v. Planned Parenthood of N. New England*, ___ U.S. ___, 126 S.Ct. 961 (2006). Applying *Ayotte*, the court concluded that it could not issue a narrower injunction. Pet. App. 41a. Specifically, the court concluded that it would be improper to issue an injunction that adds a health exception to the statute when Congress had deliberately excluded it:

> Congress did not inadvertently omit a health exception from the Act. It was not only fully aware of *Stenberg's* holding that a statute regulating "partial-birth abortion" requires a health exception, but it adopted the Act in a deliberate effort

> to persuade the Court to reverse that part of its decision.

Pet. App. 42a. To demonstrate this point, the court quoted extensively from the Congressional Record, citing, among other things, the following statement from the Act's lead Senate sponsor: "We are here because the Supreme Court defended the indefensible [in *Stenberg*]. . . . We have responded to the Supreme Court. I hope the Justices read this Record because I am talking to you. . . . [T]here is no reason for a health exception." Pet. App. 42a & n.26 (brackets in original).

Similarly, the court concluded that it would not be appropriate to devise a narrow judicial remedy for the Act's other constitutional defects:

> Congress did not unintentionally draft the broad definition of "partial-birth abortion" that gives rise to the undue burden and vagueness concerns, nor did it write the unconstitutionally overbroad language without the benefit of judicial guidance. Instead, Congress chose not to follow the roadmap the Court provided in *Stenberg*. . . . Even if we could draft a remedy that sufficiently restricted the scope of the statute (which we believe we could not properly do consistent with our limited judicial role), such a narrowing construction would serve not to cure an error but to reverse a political judgment that Congress expressly made.

Pet. App. 51a-53a.

REASONS FOR GRANTING THE PETITION

The government suggests that the Court should simply hold this case for a decision in *Carhart*, even though the Eighth Circuit addressed only the question whether the absence of a health exception rendered the Act unconstitutional. The basis for this suggestion is the government's view that, in both cases, the health exception is the primary issue. Pet. 7. But as the district court and Ninth Circuit opinions make clear, that is not necessarily so. To the contrary, this Court may ultimately find that the health exception question is the least important of the three, and may never have to reach it.

If the Court finds that the Act imposes an undue burden on a woman's right to end a previability pregnancy by banning the vast majority of previability second trimester abortions, the statute is unconstitutional whether it contains a health exception or not. *Stenberg*, 530 U.S. at 930. Similarly, if the Act fails to put physicians on notice of the conduct for which they may be prosecuted, it is void for vagueness regardless of the existence or lack of a health exception. *See, e.g., Grayned v. City of Rockford*, 408 U.S. 104, 108 (1972). Only if the Court finds that the Act *does not* ban both methods of D&E and *is not* unconstitutionally vague about the procedures it bans would the Court be required to address the absence of a health exception. In sum, the first two questions in this case are predicates to the question presented in *Carhart*. They are not, as the government has asserted, subsidiary questions. Pet. 7 (incorporating by reference Supplemental Brief for the Petitioner in *Gonzales v. Carhart*, No. 05-380, at 8-10).

In fact, with respect to vagueness, the parties did not even brief the issue in the Eighth Circuit. The government

suggests this is not a problem because the vagueness argument "substantially overlap[s]" with the argument that the Act imposed an undue burden. *Id.* at 9 & n.2. But although there may be *some* overlap between the undue burden and vagueness issues, the latter presents distinct problems as well. For example, the Ninth Circuit took issue with the Act's use of the phrase "living fetus," noting that a fetus could be considered "living" (although of course not "viable") as early as seven weeks into a pregnancy, thereby creating "additional confusion about the Act's scope." Pet. App. 39a. This aspect of the vagueness inquiry is separate from the question whether the Act bans both forms of D&E as opposed to just one.

In addition to the fact that the Eighth Circuit did not address undue burden or vagueness, if the Court finds the Act unconstitutional in any respect, it may wish to consider the applicability of *Ayotte*. Unlike the Eighth Circuit, the Ninth Circuit confronted this question. Pet. App. 1a-2a, 40a-54a. After thoroughly examining the Congressional Record, the Ninth Circuit found that because Congress had deliberately set out to defy this Court's ruling in *Stenberg*, both with respect to the procedures it banned and the exclusion of a health exception, a narrower injunction would not be appropriate. Pet. App. 42a, 51a-53a. These findings could aid the Court's consideration of the remedy issue. (Indeed, the Ninth Circuit's analysis of the Congressional Record is relevant not only to the remedy issue, but to a question that extends far beyond the abortion debate – whether Congress may, consistent with its constitutional role, respond to Supreme Court decisions in the way that it responded to *Stenberg*.)

Accordingly, the government, by suggesting that the Court hold this case for *Carhart*, is really asking the Court

to decide four extremely important, high-profile constitutional issues (undue burden, vagueness, health exception and remedy) while reviewing an appellate decision that decided *just one* of those issues. San Francisco respectfully suggests that, even if the Court theoretically could decide these questions while reviewing an appellate decision that did not so much as mention them, prudence weighs against such an approach. *Cf. Illinois v. Gates*, 462 U.S. 213, 224 (1983) ("Where difficult issues of great public importance are involved, there are strong reasons to adhere scrupulously to the customary limitations on our discretion. By doing so, we promote respect for the Court's adjudicatory process and the stability of our decisions") (internal quotations and ellipses omitted).

CONCLUSION

The Court should grant the petition in this case, adopt the questions presented set forth by the Respondents, review the decision below on the merits, and schedule the case for argument with *Carhart*.

Respectfully submitted,

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IN THE

Supreme Court of the United States

ALBERTO R. GONZALES, ATTORNEY GENERAL,

Petitioner,

—v.—

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., *et al.*,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF OF THE PLANNED PARENTHOOD RESPONDENTS IN RESPONSE TO PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Whether the Court of Appeals correctly held that the "Partial Birth Abortion Ban Act of 2003," Pub. L. No. 108-105, 117 Stat. 1201 (to be codified at 18 U.S.C. § 1531) ("Act"), is unconstitutional on its face because it effectively bans all forms of dilation and evacuation ("D&E") abortions, the most commonly used previability second-trimester abortion method, and therefore imposes an undue burden on a woman's right to end a previability pregnancy?

Whether the Court of Appeals correctly held that the Act is unconstitutionally vague because it fails to provide fair warning of the medical procedures it bans and permits arbitrary and discriminatory enforcement?

Whether the Court of Appeals correctly held that the Act is unconstitutional on its face, even if it is construed as banning only the intact form of D&E abortion, because it bans such abortions even when they are safer for the woman?

PARTIES TO THE PROCEEDING

Petitioner is Alberto R. Gonzales, Attorney General of the United States.

Respondents are Planned Parenthood Federation of America, Inc.; Planned Parenthood Golden Gate; and the City and County of San Francisco.

Respondents Planned Parenthood Federation of America, Inc. and Planned Parenthood Golden Gate are not-for-profit corporations that do not have parent corporations and are not owned in any part by a publicly held company.

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INTRODUCTION

Respondents Planned Parenthood Federation of America, Inc. and Planned Parenthood Golden Gate ("Planned Parenthood") urge this Court to grant plenary review of the decision by the United States Court of Appeals for the Ninth Circuit and to consider this case ("*Planned Parenthood Federation*") jointly with *Gonzales v. Carhart*, No. 05-380 (*cert. granted* U.S. Feb. 21, 2006) ("*Carhart*").[1] The District Court and Ninth Circuit here ruled on two fact-intensive, threshold constitutional claims that were not decided by the court of appeals in *Carhart*. Given the District Court fact-finding on these claims, conducting plenary review, rather than holding the Petition until *Carhart* is decided (as Attorney General Alberto R. Gonzales ("Government") requests), will assist the Court in ruling on the constitutionality of the Act on all of the grounds on which it was enjoined by the lower courts.[2] Planned Parenthood further urges the Court to adopt the Questions Presented herein because the sole Question Presented in the Petition does not adequately identify all three legal bases on which the lower courts here invalidated the Act.[3] *Cf.* note 8, *infra*.

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[1] Planned Parenthood agrees with Respondents in *Carhart* that the petition in that case should have been denied, *see* Respondents' Brief in Opposition, *Gonzales v. Carhart* (U.S. Nov. 18, 2005) (No. 05-380), but that issue is now moot.

[2] Planned Parenthood joins in the Government's request that if plenary review is conducted, oral argument in this matter be consolidated with oral argument in *Carhart*. Pet. at 8.

[3] The questions presented in this brief are identical to those contained in the brief of Respondents City and County of San Francisco.

COUNTER-STATEMENT

Like *Carhart*, this case challenges the constitutionality of the Act, which bans the safest and most common methods by which second-trimester, previability abortions are performed in this country—and does so without an exception for the pregnant woman's health.[4] Unlike *Carhart*, which was decided by the United States Court of Appeals for the Eighth Circuit exclusively on the grounds that the Act lacks a constitutionally mandated health exception, *Carhart v. Gonzales*, 413 F.3d 791, 803-04 (8th Cir. 2005) (declining to rule on other constitutional claims), the Ninth Circuit in this case struck down the law on three independent constitutional grounds—undue burden, vagueness, and lack of a health exception—"each of which is sufficient to justify" striking the law in its entirety. Pet. App. 14a, 54a. The Ninth Circuit's holdings, which are described below, are based in significant part on the detailed factual findings of the District Court. These factual findings are amply supported by the record.

A. The Court of Appeals' Undue Burden Holding

The Ninth Circuit found that—independent of whether the Act must contain a health exception—the Act is

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[4] The Act was simultaneously challenged in three separate lawsuits—the instant case, *Carhart*, and *National Abortion Federation v. Ashcroft*, 330 F. Supp. 2d 436 (S.D.N.Y. 2004) ("*National Abortion Federation*") (finding Act unconstitutional based on lack of health exception), *aff'd*, 437 F.3d 278 (2d Cir. 2006) (affirming unconstitutionality due to lack of health exception, but seeking additional briefing on the appropriate remedy). After the Second Circuit's merits ruling, *National Abortion Federation* was stayed until after this Court's ruling in *Carhart*. *National Abortion Federation v. Gonzales*, No. 04-5201-cv (2d Cir. March 7, 2006) (order granting motion to stay supplemental briefing pending resolution of *Gonzales v. Carhart*).

unconstitutional because it imposes an "undue burden" on a woman's right to choose to end her pregnancy prior to viability. *Id.* at 23a-24a, 32a-33a, *citing Stenberg v. Carhart*, 530 U.S. 914, 921 (2000) (striking down Nebraska statute banning so-called "partial-birth" abortions because it would ban D&Es by all forms and therefore would impose an undue burden on women seeking previability second-trimester abortions) ("*Stenberg*"). It based this conclusion in large part on the District Court's detailed fact-finding, Pet. App. 80a-85a (District Court fact-finding on undue burden claim).

Based on that fact-finding, the Ninth Circuit compared the scope of the Act with the scope of the Nebraska statute struck down in *Stenberg*, and concluded that although the two Acts differ, the differences "do[ ] not limit the Act's reach to intact D&Es and, as a result do[ ] not eliminate the undue burden the Act imposes." *Id.* at 27a. The Ninth Circuit concluded that, like the law struck down in *Stenberg*, the Act bans both the intact and non-intact forms of D&E, the abortion method used in the vast majority of previability second-trimester abortions.[5] *Id.* at 23a-33a.

In particular, the Ninth Circuit concluded that "the record demonstrates and the district court found" that in both intact and non-intact D&Es, a doctor may extract a "living fetus" to the point where either a "part of the

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[5] The courts below used the terms "intact D&E" and "non-intact D&E" rather than "D&X" and "D&E," respectively. As the Ninth Circuit stated, "[t]he labeling of the procedure is of no consequence to our analysis; however, for simplicity's sake we prefer intact and non-intact D&E. What is relevant, however, is that one could substitute D&X for intact D&E wherever the latter term appears in our opinion and nothing would change in any respect." *Id.* at 3a-4a & n.3. This brief uses the same terminology as the opinion below.

fetal trunk past the navel" or "the entire fetal head" is "outside the body of the mother." *Id.* at 27a-28a (quoting 18 U.S.C. § 1531(b)(1)(A)).[6] Relying on the District Court fact-finding, the Ninth Circuit further found that in both intact and non-intact D&Es, if the fetus has been brought "outside the body of the mother" to the point specified in the Act, "a doctor may then, in order to complete the abortion safely, need to perform an 'overt act,' other than completing delivery, that the physician knows the fetus cannot survive, if it is still living, and that 'kills' the fetus." Pet. App. 29a-30a. Finally, it found that in both intact and non-intact D&Es, the actions doctors perform that would be banned by the Act "can be performed with the requisite intent" to violate the Act. *Id.* at 31a. Indeed, the Ninth Circuit noted a particular circumstance described in the record in which a physician performing a non-intact D&E would meet all of the requirements of the procedure banned by the Act. *Id.* The Ninth Circuit concluded, in sum, that the Act does not "adequately differentiat[e] between the two forms of D&E . . . either by tracking the medical differences between intact D&E and other forms of D&E or by specifying that the forms of D&E other than the

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[6] By its terms, the Act criminalizes the conduct of any doctor who:

> (A) deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and
>
> (B) performs the overt act, other than completion of delivery, that kills the partially delivered living fetus.

18 U.S.C. § 1531(b)(1).

intact version are not covered by the prohibition." As a result, it imposes an unconstitutional burden on women's right to previability second-trimester abortions. *Id.* at 26a-27a, 32a-33a.

B. The Court of Appeals' Vagueness Holding

The Ninth Circuit's vagueness ruling was also based in significant part on the record below, Pet. App. 92a-96a (District Court fact-finding on vagueness claim). The Ninth Circuit affirmed the District Court ruling that "the Act's unconstitutional vagueness constitutes an independent ground" for invalidation. *Id.* at 33a. Relying on the testimony of expert physicians who testified in the District Court, the Ninth Circuit found that even though "a painstaking legal analysis" reveals that the Act covers both the intact and non-intact forms of D&E, the Act "taken as a whole, is not sufficiently clear . . . to guide the conduct of . . . medical practitioners." *Id.* at 33a-35a. The Court of Appeals noted that the scope of the Act was "certainly" vague if the legislative intent was to limit the Act's scope to intact D&Es because the statutory language does not contain such a limitation. *Id.* at 35a. In addition, the Ninth Circuit affirmed the District Court's conclusion that specific terms in the Act's definition are "fatally ambiguous." *Id.* For example, relying on the testimony of the expert physicians who testified at trial, the Ninth Circuit held that the term "overt act" "can plausibly encompass a range of acts involved in non-intact D&E, . . . [and thus] does nothing to remedy the statute's failure to provide adequate notice of what forms of D&E the Act prohibits and to prevent its arbitrary enforcement." *Id.* at 38a.

C. The Court of Appeals' Health Exception Holding

Like the Eighth Circuit, the Ninth Circuit found the Act unconstitutional because it lacks a health exception. *Id.* at 14a, 22a. Notably, however, it reached this conclusion applying the deferential "substantial evidence" review of Congressional findings that the Government urges. In particular, the Ninth Circuit found "on the basis of the record before Congress, of the congressional findings themselves, and of evidence introduced in the district court [*see* Pet. App. 139a-147a for the District Court fact-finding on the health exception claim based on the trial evidence], that a substantial disagreement exists in the medical community regarding whether [the procedures banned by the Act] are necessary in certain circumstances [to preserve the health of women]." *Id.* at 22a. Given this "substantial disagreement," *id.*, and this Court's holding in *Stenberg*, the Ninth Court concluded that the Act is unconstitutional because "[w]ithout a medical consensus . . . that 'a health exception is never necessary to preserve the health of women' . . . any abortion regulation . . . without a health exception is unconstitutional." *Id.* at 16a (*quoting Stenberg*, 530 U.S. at 937-38 (internal quotation marks omitted in original)).

* * *

Given the Act's unconstitutionality on each of these three, independent grounds, the Ninth Circuit engaged in an extensive analysis of the proper remedy in light of this Court's holding in *Ayotte v. Planned Parenthood of Northern New England*, ___ U.S. ___, 126 S. Ct. 961 (2006). The Court of Appeals noted that the appropriate remedy depended on the basis for holding the Act unconstitutional, and concluded that for each independent basis, albeit for different reasons, the appropriate remedy was to enjoin completely enforcement of the

Act. It therefore affirmed the District Court's judgment, which enjoined the Act in its entirety as to Planned Parenthood and its agents nationwide. Pet. App. 40a-54a; 218a.

REASONS FOR GRANTING THE WRIT

This Court should grant the writ, order plenary review in this case based on the Questions Presented herein, and consolidate the argument of this matter with argument in *Carhart* so that the legal challenges to the validity of the Act can be resolved at one time based on the most complete available record. It is particularly important that the Court grant the writ as to Questions 1 and 2 because any ruling by this Court in *Carhart* alone would not conclusively resolve these legal questions—unless this Court decides legal claims that were not decided by the Eighth Circuit. It is axiomatic, however, that "[w]here issues [were not] considered by the Court of Appeals, this Court will not ordinarily consider them." *Meyer v. Holley*, 537 U.S. 280, 292 (2003) (quoting *Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 147 n.2 (1970)) (internal quotation marks omitted). This is because "[i]n the absence of a decision by the Court of Appeals on the merits of [a] petitioner's contentions, th[e] case is not an appropriate vehicle to consider [such contentions]." *Davis v. United States*, 417 U.S. 333, 342 n.12 (1974); *see also F. Hoffman-La Roche v. Empagran S.A.*, 542 U.S. 155, 175 (2004) ("The Court of Appeals, however, did not address this argument, and, for that reason, neither shall we.") (citation omitted). As these cases make clear, contrary to the Solicitor General's unsupported assertions, *Carhart* is neither a "suitable" (Pet. at 7-8), nor "an attractive vehicle" for deciding the undue burden and vagueness claims (Supplemental Brief for the Peti-

tioner, *Carhart* (U.S. Dec. 2, 2005) (No. 05-380) ("*Carhart* Supp. Br."), at 8).[7]

Indeed, it would be particularly difficult for the Court to decide the vagueness challenge to the Act in the context of *Carhart* because that claim was not even preserved for review by the Eighth Circuit, let alone decided (*see Carhart* Supp. Br. at 9 n.2 (acknowledging that respondents in *Carhart* did not present the vagueness claim to the Eighth Circuit)). *See, e.g.*, *Adickes*, 398 U.S. at 148 n.2 ("Where issues are neither raised before nor considered by the Court of Appeals, this Court will not ordinarily consider them."); *Lawn v. United States*, 355 U.S. 339, 362 n.16 (1958) (declining to reach issue raised before trial court but not preserved before Court of Appeals, as "[o]nly in exceptional cases will this Court review a question not raised in the court below.").

The Court's usual preference for not deciding claims that were not ruled on by the court of appeals applies with particular force here, given the public importance of the issues raised in this case and *Carhart*. *Cf. Bankers Life and Cas. Co. v. Crenshaw*, 486 U.S. 71, 79-80 (1988) (policies against reaching issue not raised before lower courts apply with "special force" to issues of par-

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[7] Moreover, this Court should reach these claims even if it finds the Act unconstitutional for lack of a health exception because, *inter alia*, these claims are likely to be relevant to the remedy determination. *See* Pet. App. 41a ("Our conclusion [as to the proper remedy] is dictated in part by the grounds on which we hold the Act unconstitutional."); *id.* at 47a ("we need not rest our decision as to the appropriate remedy solely on the omission of a health exception because we have determined that the Act is unconstitutional on other grounds as well . . . . [T]he nature of these constitutional errors [in addition to the omission of a health exception] precludes us from devising a remedy any narrower that the invalidation of the entire statute . . . .").

ticular importance); *Illinois v. Gates*, 462 U.S. 213, 224 (1983) ("Where difficult issues of great public importance are involved, there are strong reasons to adhere scrupulously to the customary limitations on our discretion. By doing so we promote respect . . . for the Court's adjudicatory process [and] the stability of [our] decisions.") (internal quotation marks and citations omitted).

The Government tries to get around the fact that the vagueness claim was not preserved for review in the Eighth Circuit by asserting that this claim "substantially overlap[s]" with the undue burden analysis. *Carhart* Supp Br. at 9 n.2. But this is not correct. Both the District Court and the Court of Appeals in *Planned Parenthood Federation* considered the vagueness claim to be a distinct and independent basis for invalidating the Act. *See* Pet. App. 89a-96a; 33a-40a. Moreover, there is no doubt that, irrespective of any overlap between these claims, this Court would benefit from the lower courts' detailed factual findings and analysis on the vagueness claim in *Planned Parenthood Federation*. *Id.* at 34a n.24 (affirming use of expert testimony by a court as part of a vagueness inquiry); 92a-93a.

Even leaving aside the fact that the Eighth Circuit did not decide the vagueness and undue burden claims, the District Court's factual findings on these claims were more detailed in *Planned Parenthood Federation* than in *Carhart*. *Compare Carhart v. Ashcroft*, 331 F. Supp. 2d 805, 1030-37 (D. Neb. 2004) (*Carhart* district court analysis of undue burden claim) and *id.* at 1037-41 (*Carhart* district court analysis of vagueness claim) *with* Pet. App. 80a-85a (*Planned Parenthood Federation* district court analysis of undue burden claim); Pet. App. 92a-96a (*Planned Parenthood Federation* district court

analysis of vagueness claim); Pet. App. at 23a-33a (*Planned Parenthood Federation* Court of Appeals analysis of undue burden claim); and *id.* at 33a-40a (*Planned Parenthood Federation* Court of Appeals analysis of vagueness claim). *See also* Counter-Statement §§ A and B, *supra*. Where, as here, difficult issues of public importance are involved, this Court should resolve the legal issues with the benefit of all of the findings available on those claims—meaning those in both the *Carhart* record and the *Planned Parenthood Federation* record. *Cf. Bankers Life and Cas. Co.*, 486 U.S. at 79-80 ("any ultimate review of the question that we might undertake will gain the benefit of a well-developed record and a reasoned opinion [from the court of appeals] on the merits" particularly given public importance of the issue). As the Court observed in relation to another difficult and contentious issue (there, a proposed limitation on the exclusionary remedy):

> [F]idelity to the [customary limitations on our discretion not to decide claims "not pressed or passed on below"] guarantees that a factual record will be available to us, thereby discouraging the framing of broad rules, seemingly sensible on one set of facts, which may prove ill-considered in other circumstances . . . .

Gates, 462 U.S. at 224 (internal quotation marks and citations omitted).

The Government, attempting to justify its clear preference that this Court restrict its plenary review to the record in *Carhart*, mischaracterizes the undue burden and vagueness claims as "alternative" or "subsidiary" to the "primary" claim, which, in its view, is the health

exception claim.[8] *Carhart* Supp. Br. at 8; *see also id.* (asserting that health exception claim was the "focus" in the lower courts). This is incorrect.[9] The threshold question for this Court is: may Congress constitutionally ban the abortions that the Act defines as "partial-birth abortions"? That question turns on the clarity and scope of the Act. If Congress may not ban the abortions prohibited by the Act—either because the Act does not define the prohibited conduct with sufficient clarity or because the Act sweeps within it virtually all previability second-trimester abortions and therefore imposes an undue burden on the abortion right—the Act must be invalidated. If, instead, this Court determines that it is constitutionally permissible to ban what Congress defines as "partial-birth abortion" in the way Congress has defined that term, then the Court must consider whether such a ban is unconstitutional without an exception for when the banned abortions are safer for the woman (*i.e.*, a "health exception"), and, if so, how to remedy such a deficiency. Because the undue burden and vagueness claims are threshold issues, the Court should conduct a plenary review of *Planned Parenthood Federation* so that it has the benefit of the record and the District Court fact-finding on those claims in a case where they were actually decided by the Court of Appeals.

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[8] It is notable that the Government is so intent on minimizing the significance of the undue burden and vagueness claims that it fails to mention them explicitly in its single Question Presented. As the Ninth Circuit recognized, however, these are independent constitutional grounds for invalidating the Act. Pet. App. 11a-12a.

[9] The undue burden and vagueness claims are certainly not "subsidiary" in the context of the formulation of the proper remedy if Planned Parenthood prevails on any of its claims. *See* Pet. App. 47a-48a; *see also* note 7, *supra*.

Finally, any ruling upholding the Act would require overturning this Court's very recent precedent in *Stenberg*. When this Court considers overturning its own precedent, "whether facts have . . . changed, or come to be seen . . . differently" is one of the "prudential and pragmatic considerations" to which this Court looks. *Planned Parenthood of S.E. Pa. v. Casey*, 505 U.S. 833, 854-55 (1992). Thus, having as complete a record as possible on which to make this determination is imperative.

CONCLUSION

This Court should grant the writ, order plenary review in this case on the basis of the Questions Presented herein, and consolidate the argument of this matter with argument in *Carhart*.

Respectfully submitted,

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In The
Supreme Court of the United States

ALBERTO R. GONZALES,
ATTORNEY GENERAL,

Petitioner,

v.

PLANNED PARENTHOOD
FEDERATION OF AMERICA, INC., ET AL.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

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QUESTIONS PRESENTED

1. Whether the Court of Appeals correctly held that the "Partial Birth Abortion Ban Act of 2003," Pub. L. No. 108-105, 117 Stat. 1201 (18 U.S.C. § 1531 (Supp. III 2003)) ("Act"), is unconstitutional on its face because it effectively bans all forms of dilation and evacuation ("D & E") abortions, the most commonly used previability second-trimester abortion method, and therefore imposes an undue burden on a woman's right to end a previability pregnancy?

2. Whether the Court of Appeals correctly held that the Act is unconstitutionally vague because it fails to provide fair warning of the medical procedures it bans and permits arbitrary and discriminatory enforcement?

3. Whether the Court of Appeals correctly held that the Act is unconstitutional on its face, even if it is construed as banning only the intact variant of D & E abortion, because it bans such abortions even when they are safer for the woman?

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STATEMENT OF THE CASE

This is a case in which Congress deliberately sought to usurp this Court's constitutional authority at a time in our history when protections for individual liberties, and strict adherence to the rule of law, are as important as ever before.

1. In the years leading up to this Court's decision in *Stenberg v. Carhart*, 530 U.S. 914 (2000), Congress made several attempts to ban what it terms "partial-birth abortions."[1] Congress passed such bans in 1996 and 1997. President Clinton vetoed both bills because neither contained an exception that would allow a physician to perform a banned procedure if a woman's life or health required it. *See* H.R. 1833, 104th Cong. (as passed by Congress and vetoed by the President; veto override failed in Senate, September 26, 1996); H.R. 1122, 105th Cong. (as passed by Congress and vetoed by the President; veto override failed in Senate, September 18, 1998). Thus, in the President's view, they were unconstitutional. *See* H. Doc. No. 104-198 (142 Cong. Rec. H3338 (1996)); H. Doc. No. 105-158 (143 Cong. Rec. H8891-04 (1997)).

In the year leading up to this Court's decision in *Stenberg*, both houses of Congress approved new "partial-birth abortion" bans. *See* H.R. 3660, 106th Cong. (as passed by House, April 5, 2000); S. 1692, 106th Cong. (as passed by Senate, October 21, 1999); S. 1692, 106th Cong.

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[1] Contrary to the Government's representation (Brief for the Petitioner 2), "partial-birth abortion" does not have a fixed meaning. It is a term of art that means whatever the applicable statute says it means. *See Stenberg*, 530 U.S. at 950 (O'Connor, J., concurring) (comparing definitions of "partial-birth abortion" in statutes enacted by the Nebraska, Kansas, Utah and Montana legislatures).

(as passed by House, May 25, 2000). These bills, which Congress never enacted, defined "partial-birth abortion" as:

> an abortion in which the person performing the abortion deliberately and intentionally –
>
> (A) vaginally delivers some portion of an intact living fetus until the fetus is partially outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the fetus while the fetus is partially outside the body of the mother; and
>
> (B) performs the overt act that kills the fetus while the intact living fetus is partially outside the body of the mother.

2. This Court decided *Stenberg* on June 28, 2000. *Stenberg* invalidated a Nebraska statute that banned "partial-birth abortions," defined as:

> deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child.

Neb. Rev. Stat. Ann. § 28-326(9) (Supp. 1999).

This Court struck down the Nebraska statute for two reasons. First, although counsel for Nebraska argued its legislature had intended to ban only intact D & Es, the Court found the above definition of "partial-birth abortion"

broad enough to reach non-intact D & Es.[2] Accordingly, the ban placed "'a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus'" in violation of *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). *Stenberg*, 530 U.S. at 938-39 (quoting *Casey*). Second, the statute lacked an exception that would allow a physician to perform a banned procedure if a woman's health required it. *Id.* at 930-31.

Stenberg provided clear instructions for how to ban intact D & Es in a manner that comports with *Casey*. First, the legislation must make plain – by defining "partial-birth abortion" in a manner that uses medical terms and tracks the precise steps taken in performing an intact D & E[3] – that before viability a physician is permitted to perform a non-intact D & E. *Id.* at 939-40; *see also id.* at 950 (O'Connor, J., concurring). Second, the legislation must permit a physician to perform an intact

---

[2] The courts below used the terms "intact D & E" and "non-intact D & E" rather than "D & X" and "D & E," respectively. As the Ninth Circuit stated, "[t]he labeling of the procedure is of no consequence to our analysis; however, for simplicity's sake we prefer intact and non-intact D & E. What is relevant, however, is that one could substitute D & X for intact D & E wherever the latter term appears in our opinion and nothing would change in any respect." Pet. App. 3a-4a & n.3. This brief uses the same terminology as the opinions below.

[3] Intact D & E is defined by American College of Obstetricians and Gynecologists as:

> (1) the deliberate dilation of the cervix, usually over a sequence of days;
>
> (2) instrumental conversion of the fetus to a footling breech;
>
> (3) breech extraction of the body, excepting the head; and
>
> (4) partial evacuation of the intercranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus.

149 Cong. Rec. S3480 (daily ed. March 11, 2003).

D & E if the woman's health requires it. *Id.* at 930-31; *see also id.* at 947-48 (O'Connor, J., concurring).

3. Congress responded to *Stenberg* by passing the Partial-Birth Abortion Ban Act of 2003, Pub. L. No. 108-105, 117 Stat. 1201 (18 U.S.C. § 1531 (Supp. III 2003)) ("Act"). Petitioner (sometimes, the "Government") claims that, "[i]n drafting the Act, Congress deliberately sought to remedy the deficiencies identified by this Court in the statute at issue in *Stenberg*. . . ." Brief for the Petitioner ("Pet. Br.") 3. However, the Act's language, legislative findings and congressional history demonstrate that the sponsors did *not* set out to comply with *Stenberg*. Instead, they set out to overrule *Stenberg*.

The Act defines "partial-birth abortion" as:

> (A) deliberately and intentionally vaginally deliver[ing] a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and
>
> (B) perform[ing] the overt act, other than completion of delivery, that kills the partially delivered living fetus.

Act § 3, 117 Stat. 1206-1207 (18 U.S.C. § 1531(b)(1) (Supp. III 2003)).

This language fails to comply with *Stenberg* in two respects. First, although the above definition uses different language than the statutes previously enacted by Congress and the Nebraska legislature, it does not comport with

Stenberg's instructions for drafting a constitutional ban on intact D & E. The Act does not, for example, expressly ban only intact D & Es, or expressly exclude non-intact D & Es and inductions; and its language does not track the most commonly-used medical definition of intact D & E. *See supra* note 3.

During the Senate debate on the Act, Sen. Feinstein pointed out that the sponsors had not merely failed but actually *refused* to redraft the Act to incorporate the accepted medical definition of intact D & E:

> The sponsors of the bill have refused to use a definition of D & X that I suggested and that tracks the medical definition submitted by the American College of Obstetrics and Gynecologists. Why? Why would they refuse to use a definition suggested by the elite medical group of obstetricians and gynecologists who deal with this issue – a definition that would enable those obstetricians and gynecologists to know exactly what this legislation makes a crime?
>
> * * * *
>
> The refusal of the sponsors of the bill to accept the medical definition of intact D & E is revealing. It makes it clear they are not really intent or interested in banning intact D & E or D & X, but, rather, they seek to muddy the waters to make it harder for women to get a legal abortion using other legal and acceptable techniques.

149 Cong. Rec. S12936 (daily ed. October 21, 2003) (statement of Sen. Feinstein).

During the House debates, Rep. Nadler offered a similar criticism:

> This bill as written fails every test the Supreme Court has laid down for what may or may not be a constitutional regulation on abortion. It reads almost as if the authors went through the Supreme Court's recent decision in *Stenberg v. Carhart* and went out of their way to thumb their noses at the Supreme Court.

H.R. Rep. No. 108-58, 108th Cong., 1st Sess., at 73-74.[4] The House and Senate sponsors who rose to respond to Sen. Feinstein and Rep. Nadler's arguments did not address why they refused to define "partial-birth abortion" in a manner that tracked the medical definition of intact D & E.

Second, the sponsors deliberately excluded a health exception from the Act, even though *Stenberg* unambiguously requires one. *See Stenberg*, 530 U.S. at 930-31. Several members of Congress attempted to correct this constitutional infirmity by offering amendments that would have added a health exception to the Act, but Congress voted them down. *See* 149 Cong. Rec. H4948

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[4] *See also* 149 Cong. Rec. S3576 (daily ed. March 12, 2003) (statement of Sen. Mikulski) ("The proponents of this legislation say they have made changes to the bill to address the Supreme Court's ruling [in *Stenberg*]. They have not. . . . It still does not clearly define the procedure it claims to prohibit."); 149 Cong. Rec. S3395 (daily ed. March 10, 2003) (statement of Sen. Boxer) ("[The bill] puts an undue burden because we don't know at what stage the woman is going to get this abortion and whether this procedure applies to it or not."); 149 Cong. Rec. H4924 (daily ed. June 4, 2003) (statement of Rep. Green) ("[this legislation] continues to flout the Supreme Court's rulings by continuing to ban certain procedures. . . ."); 149 Cong. Rec. H4941 (daily ed. June 4, 2003) (statement of Rep. Kirk) ("We are setting Congress up for a defeat at the hands of our highest Court, rendering the action we take today totally ineffective and the current law permitting late-term abortions unchanged.").

(daily ed. June 4, 2003), 149 Cong. Rec. S3611 (daily ed. March 12, 2003), 149 Cong. Rec. S3579 (daily ed. March 12, 2003); *see also* 149 Cong. Rec. S3481-82 (daily ed. March 11, 2003) (statement of Sen. Durbin, offering amendment 259); 149 Cong. Rec. S3483-84 (daily ed. March 11, 2003) (statement of Sen. Collins).

The Act's chief Senate sponsor explained that he had excluded a health exception, and would oppose any amendment to add one, because he disagrees with that constitutional requirement:

> Health is an exception that swallows the rule. . . . [w]hat this provision did, and that is what the Court wanted to do, was to give absolute latitude to the doctor to do whatever the doctor wanted to do in consultation with the patient. So the health exception is no exception at all. It is a barred antiprohibition. So understand that the health exception bars the bill, stops the bill from having any effect. So that is why we resist.

149 Cong. Rec. S12942 (daily ed. October 21, 2003) (statement of Sen. Santorum).

The Government claims Congress permissively circumvented *Stenberg* with respect to the health exception requirement by making different factual findings than the Court made in *Stenberg*. Pet. Br. 18-27. Specifically, Congress rejected *Stenberg*'s finding that there was "substantial medical authority" that the ban would pose threats to some women's health; and instead "found" the opposite, namely, that "[a] moral, medical, and ethical consensus exists" that intact D & E is never necessary to preserve the health of *any* woman. Act §§ 2(1), (14(O)).

For the reasons set forth in the brief filed by Respondents Planned Parenthood Federation of America and Planned Parenthood Golden Gate (collectively, "Planned Parenthood"), Congress' findings of fact relating to the health exception issue are entirely constructed and demonstrably false.[5] Nevertheless, the Act's sponsors apparently believed that by announcing utterly unsupported "findings," they could overrule *Stenberg*. *See* Act § 2(8)-(13).

Indeed, throughout the floor debates, the Act's supporters made plain that their intent was to overrule *Stenberg* and strike at the heart of this Court's abortion jurisprudence:

> The reason we are back is not *just* to say the Court was wrong or that we disagree with the Court's judgment on constitutionality, although I do. I have to say the Court's view of the constitutionality of abortion statutes is really quite remarkable. . . . The Court has basically said there are no restrictions on abortion.
>
> * * * *
>
> I hope the Justices read this **RECORD** because I am talking to you. . . . I understand the Justices' feelings on the issue of abortion. It is evident from your decisions. It is obvious from your position. But you can't ignore the facts. Don't ignore the facts, because they are clear. . . . It is crystal

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[5] *See also* H.R. Rep. No. 108-58 at 142 (Rep. Scott) ("It's one thing to reach findings, but it's another thing to just make up findings"); 149 Cong. Rec. S3604 (daily ed. March 12, 2003) (statement of Sen. Lautenberg) ("There is an old saying: Everyone is entitled to their own opinion, but not their own facts.").

> clear. . . . [T]here is no reason for a health exception. Take the obligation you have seriously because I can tell you, the Members of this body do. We take our constitutional obligations dead seriously. The weight of evidence is not just overwhelming, it is dispositive. Listen. Learn. Decide justly.

149 Cong. Rec. S3456, S3486 (daily ed. March 11, 2003) (statements of Sen. Santorum).

In the House, Reps. Linder and Delay similarly rejected calls to comply with *Stenberg* and rallied Congress to defy this Court. Rep. Linder stated:

> [Opponents of the Act] tell us we have no right to legislate a ban on this horrible practice because the Supreme Court says we cannot. . . . I believe the Congress has its own duty to create and pass laws that protect the people of this country.

148 Cong. Rec. H5349 (daily ed. July 24, 2002) (statement of Rep. Linder).

Rep. Delay c[illegible]ed in:

> I came to the House to pass very strong, important legislation and then to fight in the courts for my position. I do not let the courts decide what direction I go.

149 Cong. Rec. H4946 (daily ed. June 4, 2003) (statement of Rep. Delay).

4. President Bush signed the Act into law on November 5, 2003. Planned Parenthood filed suit in the United States District Court for the Northern District of California, asking that it restrain the Government from enforcing the Act. The case was assigned to Judge Phyllis

Hamilton, who temporarily restrained enforcement of the Act. The City and County of San Francisco ("City") intervened as a plaintiff to protect the interests of medical providers and patients at San Francisco General Hospital ("SFGH"). SFGH is a county facility that contains a major trauma center and serves, among others, women who are too poor to go elsewhere, and women who are too sick to obtain treatment outside of a hospital setting.

Judge Hamilton combined the preliminary injunction hearing with a bench trial on the merits. The trial began March 29, 2004, and lasted three weeks. The district court heard live testimony from thirteen expert witnesses, received deposition transcripts from six additional expert witnesses, and reviewed the relevant portions of the Congressional Record. On June 1, 2004, the district court ruled the Act unconstitutional and permanently enjoined its enforcement. Pet. App. 55a-218a.

The district court held that the Act suffers from three separate constitutional infirmities. First, after analyzing the expert testimony, it found that the Act has the practical effect of banning the same abortion procedures as the Nebraska statute struck down in *Stenberg*. Pet. App. 80a-85a. Accordingly, it places an undue burden on women seeking a previability abortion in violation of *Casey*. Second, it found the Act unconstitutionally vague because physicians reading it "do not understand exactly what the Act prohibits." Pet. App. 92a. Third, it found that, even if the Act could somehow be construed as only banning intact D & Es in a manner that was not unduly vague, it would still be unconstitutional for failure to include a health exception. Pet. App. 213a-217a.

The Ninth Circuit affirmed on all three grounds. Pet. App. 1a-54a. It also addressed the question of how to remedy the Act's constitutional defects in light of this Court's recent decision in *Ayotte v. Planned Parenthood of N. New England*, 126 S. Ct. 961 (2006). Applying *Ayotte*, the court concluded that it had to invalidate the Act in its entirety. Pet. App. 41a. Specifically, the court decided that it would be improper to issue an injunction that adds a health exception to the statute when Congress had deliberately excluded it:

> Congress did not inadvertently omit a health exception from the Act. It was not only fully aware of *Stenberg's* holding that a statute regulating "partial-birth abortion" requires a health exception, but it adopted the Act in a deliberate effort to persuade the Court to reverse that part of its decision.

Pet. App. 42a. This Court granted certiorari to consider the constitutionality of the Act. *Gonzales v. Planned Parenthood Federation of America, et al.*, 126 S. Ct. 2901 (2006).

SUMMARY OF ARGUMENT

The City joins in Planned Parenthood's brief, and in an effort to avoid duplication will not reiterate arguments made therein. Instead, the City writes to urge the Court to reject Congress' attempt to usurp its constitutional authority under *Marbury v. Madison*, 5 U.S. [1 Cranch.] 137, 177 (1803).

This case is about much more than the constitutionally-protected right to an abortion. It is about whether the

coordinate branches of government can get away with defying the Court's ultimate authority "to say what the law is." *Id.* The Court has been faced with such acts of defiance throughout our nation's history, from the showdown between federal and state troopers in the wake of *United States v. Peters*, 9 U.S. [5 Cranch.] 115 (1809), to the southern States' resistance to *Brown v. Board of Education*, 347 U.S 483 (1954), to the acts of congressional defiance overturned in *Dickerson v. United States*, 530 U.S. 428 (2000), *City of Boerne v. Flores*, 521 U.S. 507 (1997) and *United States v. Eichman*, 496 U.S. 310 (1990).

The Court has consistently responded to acts of defiance – from whatever quarter – by reasserting its authority as the ultimate interpreter of the Constitution. And partly for that reason, over time our democracy has matured to the point where such acts of defiance are relatively infrequent and the rule of law is generally treated with respect.

The Act, like the statutes in *Dickerson*, *City of Boerne* and *Eichman*, is unquestionably an episode of congressional defiance. Far from complying with the Court's ruling in *Stenberg*, the Act's sponsors insisted over repeated objections by their colleagues that they would *not* comply. They drafted the statute so that it has the effect of banning both intact and non-intact D & Es; and they defied *Stenberg*'s requirement that an abortion restriction include a health exception.

The sponsors made no secret of the fact that they had set out to defy the Court:

> I hope the Justices read this **RECORD** because I am talking to you. . . . Take the obligation you have seriously because I can tell you, the Members of

> this body do. We take our constitutional obligations dead seriously. . . . Listen. Learn. Decide justly.

149 Cong. Rec. S3486 (daily ed. March 11, 2003) (statement of Sen. Santorum).

The structure of our Constitution is designed in part to protect us from ourselves. "It will not be denied, that power is of an encroaching nature, and that it ought to be effectually restrained from passing the limits assigned to it." The Federalist No. 48 (James Madison). The past half-decade has seen our democracy enter a delicate time in its history. Our collective need to be protected by Congress and the Executive Branch has undoubtedly increased; but so has the need to safeguard the civil liberties of politically unpopular minorities. This Court has never allowed Congress to overturn a constitutional precedent. Now is not the time for it to send a message to the coordinate branches, or for that matter to the States, that public officials may ignore or overrule Supreme Court rulings because they happen to disagree with them.

ARGUMENT

I. THROUGHOUT ITS HISTORY, THE COURT HAS CONSISTENTLY REJECTED ATTACKS ON ITS CONSTITUTIONAL AUTHORITY.

Article III of the Constitution established a "judicial department" with the "province and duty . . . to say what the law is." *Marbury v. Madison*, 5 U.S. [1 Cranch.] 137, 177 (1803). As the Court explained in *City of Boerne v. Flores*, 521 U.S. 507 (1997):

> When the Court has interpreted the Constitution, it has acted within the province of the Judicial Branch, which embraces the duty to say what the law is. *Marbury v. Madison*, 1 Cranch, at 177, 2 L. Ed. 60. When the political branches of the Government act against the background of a judicial interpretation of the Constitution already issued, it must be understood that in later cases and controversies the Court will treat its precedents with the respect due them under settled principles, including *stare decisis*, and contrary expectations must be disappointed.

Id. at 536.

Politically-motivated attacks on the Court's constitutional authority are as old as the Constitution itself. In the early days of our Republic, such defiance typically originated in the several States; more recently, challenges to the Court have originated from the co-equal branches of the federal government. *See generally* Larry Alexander & Frederick Schauer, *On Extrajudicial Constitutional Interpretation*, 110 Harv. L. Rev. 1359 (1997); Dale Carpenter, *Judicial Supremacy and its Discontents*, 20 Const. Comment. 405 (2003); Dwight Wiley Jessup, Reaction and Accomodation: The Supreme Court & Political Conflict, 1809-1835 (1987).

The earliest attack on the Court's constitutional authority was Pennsylvania's armed resistance to its decision in *United States v. Peters*, 9 U.S. [5 Cranch.] 115 (1809). William O. Douglas, *Interposition and the Peters Case*, 1778-1809, 9 Stan. L. Rev. 3, 9 (1956); Jessup, *supra*, at 140-41. *Peters* addressed the seemingly straightforward question of which of three claimants was entitled to prize money for having captured a British ship during the

Revolutionary War. *Peters*, 9 U.S. [5 Cranch.] at 136-37; Douglas, *supra*, at 9; Jessup, *supra*, at 140-41. Several parties – including Gideon Olmstead, who had led a daring prisoner's rebellion against the ship's captain – claimed entitlement to the money, which had been placed in the hands of the state treasury. *Peters*, 9 U.S. [5 Cranch.] at 137; Douglas, *supra*, at 4; Jessup, *supra*, at 140-42. Olmstead sought relief in Pennsylvania state court, where a jury awarded him just one-fourth of the total prize. Douglas, *supra*, at 5; Jessup, *supra*, at 141.

Unhappy, Olmstead appealed to a committee of the Continental Congress, which at the time had appellate jurisdiction over state court admiralty decisions. The committee reversed the state court decision. Pennsylvania refused to comply with the committee's ruling, stating that a congressional committee lacked the constitutional authority to overrule a Pennsylvania jury. Douglas, *supra*, at 406; Jessup, *supra*, at 141-42.

Years later, Olmstead sought and obtained a district court order requiring Pennsylvania to obey the congressional committee's ruling, but Pennsylvania would not relent. To the contrary, the Governor urged the legislature to resist the district court order, and the legislature passed a statute defying the district court's decree. Jessup, *supra*, at 142. The statute further ordered the Governor "to protect the just rights of the State from any process issued by an [sic] Federal Court." Jessup, *supra*, at 142 (citations omitted). Apparently for fear of political fallout, the district court judge declined to take steps to enforce the order. Douglas, *supra*, at 8; Jessup, *supra*, at 142.

Olmstead petitioned this Court for a writ requiring the district court to enforce the federal order. *Peters*, 9 U.S.

[5 Cranch.] at 115. This Court (Marshall, C.J.) granted the petition, stating:

> If the Legislatures of the several States may, at will, annul the judgments of the Courts of the United States, and destroy the rights acquired under those judgments, the constitution itself becomes a solemn mockery; and the Nation is deprived of the means of enforcing its laws by the instrumentality of its own tribunals.

Peters, 9 U.S. [5 Cranch.] at 136.

In response to *Peters*, the Governor of Pennsylvania – backed by the State legislature – called up the militia and ordered it to resist enforcement of the federal order. Douglas, *supra*, at 9; Jessup, *supra*, at 143. When the U.S. Marshal tried to effect service of this Court's writ, he was met by members of the Pennsylvania militia armed with bayonets. Douglas, *supra*, at 9; Jessup, *supra*, at 143-44. Not to be outdone, the U.S. Marshal called up 2,000 federal troops to help execute service of the writ. Douglas, *supra*, at 9; Jessup, *supra*, at 144. The Pennsylvania Governor asked then-President James Madison to intervene, but the President refused to do so. Douglas, *supra*, at 9-10; Jessup, *supra*, at 144. Pennsylvania ultimately withdrew the militia and accepted the *Peters* decision. Douglas, *supra*, at 10-11; Jessup, *supra*, at 144.

Pennsylvania's challenge to the Court's authority was followed by similar acts of defiance by other States in the Union, among them Virginia and Ohio. In one example, the Virginia high court attempted to rebel against the Court's ruling in *Fairfax's Devisee v. Hunter's Lessee*, 11 U.S. [7 Cranch.] 603 (1812). In *Fairfax's Devisee*, this

Court overturned a ruling of the Virginia court attempting to divest property rights protected by federal treaties. *Id.* at 627-28. Enraged, the Virginia court announced that the Judiciary Act (by which this Court had exercised appellate jurisdiction) was unconstitutional; and further, that States could nullify measures of the national government they viewed to be unconstitutional, and decisions of the federal judiciary they viewed as invalid. Jessup, *supra*, at 162. This Court responded by upholding the Judiciary Act and generally reaffirming its supremacy with respect to interpretations of federal law. *See Martin v. Hunter's Lessee*, 14 U.S. 304, 342-44 (1816).

In another example, Ohio defied the Court's ruling in *M'Cullough v. Maryland*, 17 U.S. 316 (1819), which held that the States lacked the authority to tax the National Bank ("the Bank"). *See* Jessup, *supra*, at 183-213. Congress had chartered the Bank, a quasi-public entity, in 1816, and it soon grew to become the "biggest single financial transactor" in the U.S. economy. *Id.* at 183-84. In 1818, the Bank altered its lending and monetary policies in an effort to curb inflation, thereby triggering the depression of 1819. *Id.* at 185. As a result, the Bank became the target of tremendous hostility in the States, some of which attempted to tax it out of business. *Id.* at 185-87. The Ohio legislature enacted a tax against the Bank in 1819. *Id.* at 232-33. The Ohio statute, appropriately termed the "Crow-Bar Law," specifically required Ohio's auditor, Ralph Osborn, to enter the Bank and physically seize assets to satisfy the tax. *Id.* at 233.

One month after Ohio enacted its tax on the Bank, this Court ruled in *M'Cullough* that a similar Maryland tax was unconstitutional. *Id.* at 232. Subsequently, Bank officials filed a petition in federal court to enjoin Osborn

from seizing federal assets. *Id.* at 233. In the meantime, Osborn commissioned a collector, John Harper, to enter the Bank and seize sufficient assets to satisfy the tax. Harper entered the Bank, took possession of the vault, and removed $120,422. *Id.* The federal court issued a writ ordering Harper and Osborn to return the money, but they refused. *Id.* Subsequently, the Ohio treasurer, Hiram Curry, returned most of the money to the Bank. *Id.* The Bank pressed criminal charges against Harper and Osborn, who were jailed for three months. *Id.*

The Ohio legislature responded by adopting resolutions against the Bank and the federal court. One resolution expressly rejected not only *M'Cullough* but *Marbury*; it announced that "any decision of the United States Supreme Court in questions of political rights and political powers 'is not conclusive of rights decided by it.'" *Id.* at 235 (citation omitted). The legislature subsequently passed a statute that purported to nullify *M'Cullough*. *Id.* at 235-36.

Nearly two years later, the lower federal court invalidated Ohio's Bank tax and ordered Ohio to pay restitution and penalties to the federal government. *Id.* at 240. The Ohio treasurer refused to comply with that order, and was arrested for contempt. The U.S. Marshal removed the keys to the Ohio treasury from the treasurer's pocket, went to the state treasury, and seized assets to satisfy the federal judgment. *Id.* at 241. Ohio appealed the decision to this Court, which reaffirmed *M'Cullough* in *Osborn v. Bank of the United States*, 22 U.S. 738 (1824).

Defiance of the Court has not been limited to the States. Federal officials have also resisted its authority from time to time. In perhaps the most famous early act of

Executive Branch defiance, President Andrew Jackson rejected *Worcester v. Georgia*, 31 U.S. 515 (1832), in which the Court held that the State of Georgia had no jurisdiction over territory granted under federal law to the Cherokee Indian Tribe. *Id.* at 593-95 (Marshall, C.J.). President Jackson's policy with respect to the Indian tribes was that they were legally required to submit to the laws of the States in which they lived. Homer Carey Hockett, Political and Social Growth of the American People, 1492-1852, at 502 (1937). In his first annual message to Congress, Jackson announced that all Indian tribes must submit to state law or migrate west of the Mississippi. *Id.* Congress agreed, and passed a statute effectuating Jackson's policy. *Id.* In Georgia, state officials began to take steps towards extending jurisdiction over members of the Cherokee Tribe, who turned to the courts for relief. In *Worcester*, this Court held that the Cherokees were entitled to territorial integrity and governmental autonomy pursuant to binding federal treaties. *Worcester*, 31 U.S. at 593-95.

President Jackson refused to comply with the Court's order, reputedly announcing: "John Marshall has made his decision; now let him enforce it." Hockett, *supra*, at 502. Jackson eventually sent federal troops into Georgia, but they evicted the Cherokees, not the Georgians. *See id.* at 503. He later made explicit his view that Supreme Court opinions did not bind Congress or the Executive Branch:

> The authority of the Supreme Court must not . . . be permitted to control the Congress or the Executive when acting in their legislative capacities, but to have only such influence as the force of their reasoning may deserve. (Andrew Jackson, *Veto Message* (July 10, 1832), in 2 A Compilation of the

Messages and Papers of the Presidents 576, 582 (1907).)

More than a century after *Worcester*, President Eisenhower faced the question of how a President should respond to a Supreme Court decision with which he disagrees. That decision was *Brown v. Board of Education*, 347 U.S 483 (1954). When the Court first decided *Brown*, Eisenhower announced that he would play no role in enforcing it. *See* Lucas A. Powe, Jr., The Warren Court and American Politics 35-36, 157 (2000). Subsequently, however, Eisenhower reversed course and ordered 1,100 federal troops from the 101st Airborne into Little Rock to desegregate a public school. *Id.* at 157-59.

In contrast to Eisenhower's actions, members of Congress and local officials from the southern States pursued a strategy of prolonged resistance to *Brown*. *Id.* at 60-62, 157 *et seq.*; *see also* Dale Carpenter, *Judicial Supremacy and its Discontents*, 20 Const. Com. 405, 417-20 (2003). For example, southern Democrats in Congress came together to issue an attack on *Brown* in the form of a document that became known as the "Southern Manifesto." Powe, *supra*, at 60-62. The Manifesto declared that this Court had "abandoned the Constitution" and it was up to federal and state officials to "reclaim it." *Id.* at 61. By the mid-1950's, several southern states had adopted pro-segregation statutes. *Id.* at 61, 66-68; Carpenter, *supra*, at 417-18. The legislatures of Alabama, Mississippi and Louisiana issued formal announcements refusing to comply with what they saw as the Court's flawed interpretation of the Fourteenth Amendment, and several other states either encouraged or tolerated popular resistance through "vigilantism and mob violence." Carpenter, *supra*, at 418.

In 1958, all nine justices of the Court famously rebuked the southern States' defiance of *Brown* by issuing a joint opinion stating that *Brown* was the law of the land and every public school in the country had to comply with its mandate:

> [T]he interpretation of the Fourteenth Amendment enunciated by this Court in the Brown case is the supreme law of the land, and Art. VI of the Constitution makes it of binding effect on the States "any Thing in the Constitution or Laws of any State to the Contrary notwithstanding."

Cooper v. Aaron, 358 U.S. 1, 18 (1958) (citation omitted).

In the years since *Cooper*, governmental actors and the public as a whole have generally come to accept that this Court is the final and supreme authority on constitutional interpretation. Carpenter, *supra*, at 408-12. As compared to our nation's early history, attempts to usurp the Court's authority have become relatively rare. *Id.* at 409-10. Notably, however, such defiance has taken a new form, namely, efforts by Congress to overrule constitutional precedents.

In *Dickerson v. United States*, 530 U.S. 428 (2000), the Court considered an act of Congress that purported to eliminate the Fourth Amendment requirement, first identified in *Miranda v. Arizona*, 384 U.S. 436 (1966), that the fruits of custodial interrogations are only admissible if the suspect is advised of his rights prior to the interrogation. *Dickerson*, 530 U.S. at 435. The federal statute at issue in *Dickerson* purported to replace the so-called *Miranda* warnings with the general rule in effect before *Miranda* was decided, namely, that the fruits of custodial interrogations were admissible if voluntarily obtained.

Dickerson, 530 U.S. at 431, 441-43. The Court struck down that statute, ruling that Congress could not "legislatively supersede our decisions interpreting and applying the Constitution." *Id.* at 437 (*citing City of Boerne v. Flores*, 521 U.S. 507 (1997)).

In *City of Boerne*, the Court considered the constitutionality of the Religious Freedom Restoration Act of 1993, 42 U.S.C. §§ 2000bb *et seq.* ("RFRA"). *City of Boerne*, 521 U.S. at 511. Congress had enacted RFRA in direct response to *Employment Div., Dept. of Human Resources of Oregon v. Smith*, 494 U.S. 872 (1990), in which the Court held that neutral, generally applicable laws that burden religious practices may withstand constitutional challenge even if they are not supported by a compelling governmental interest. *See id.* at 512-13; *see generally* Christopher L. Eisgruber & Lawrence G. Sager, *Why The Religious Freedom Restoration Act Is Unconstitutional*, 69 N.Y.U. L. Rev. 437, 437 (1994).

As with *Stenberg*, the Court's constitutional interpretation in *City of Boerne* was "debated by Members of Congress in hearings and floor debates. Many criticized the Court's reasoning, and this disagreement resulted in the passage of RFRA," which purported to overrule *Smith*. *City of Boerne*, 521 U.S. at 515. At the time of its passage, RFRA enjoyed overwhelming popular and political support. As Eisgruber & Sager describe:

> The Act sailed through both houses of Congress, passing unanimously in the House of Representatives and drawing only three votes in opposition in the Senate. President Clinton declared that the signing ceremony had a "majestic quality" because the new law affirmed "the historic role that people of faith have played in the history of this country

> and the constitutional protections those who profess and express their faith have always demanded and cherished."

Eisgruber & Sager, *supra*, at 438.

The Court invalidated RFRA, in part because it was an attempt by Congress to usurp the Court's constitutional authority:

> The first eight Amendments to the Constitution set forth self-executing prohibitions on governmental action, and this Court has had primary authority to interpret those prohibitions.
>
> * * * *
>
> If Congress could define its own powers by altering the Fourteenth Amendment's meaning, no longer would the Constitution be "superior paramount law, unchangeable by ordinary means." It would be "on a level with ordinary legislative acts, and, like other acts, . . . alterable when the legislature shall please to alter it." *Marbury v. Madison*, 1 Cranch., at 177, 2 L.Ed. 60. Under this approach, it is difficult to conceive of a principle that would limit congressional power. Shifting legislative majorities could change the Constitution and effectively circumvent the difficult and detailed amendment process contained in Article V.

City of Boerne, 521 U.S. at 524, 529 (citation omitted).

Finally, in *United States v. Eichman*, 496 U.S. 310 (1990), the Court considered the constitutionality of the Flag Protection Act, 18 U.S.C. § 700 (amended in 1989) (originally enacted as Pub. L. 90-381 (1968)). *Eichman*, 496 U.S. at 312. The Flag Protection Act provided in pertinent part:

> Whoever knowingly mutilates, defaces, physically defiles, burns, maintains on the floor or ground, or tramples upon any flag of the United States shall be fined under this title or imprisoned for not more than one year, or both.

18 U.S.C. § 700(a)(1).

Congress passed the Flag Protection Act after the Court decided *Texas v. Johnson*, 491 U.S. 397 (1989), in which it held that a Texas prohibition on destroying or defiling the American flag violated the First Amendment. *Id.* at 416-17. In *Eichman*, the Government argued on behalf of Congress that the federal statute's language distinguished it from the statute invalidated in *Johnson*, but in any case, the Court should overrule *Johnson* in view of the national consensus against flag desecration. *Eichman*, 496 U.S. at 317-18. The Court struck down the Flag Protection Act and reaffirmed *Johnson*. *Id.* at 317-19.

The Court has consistently rejected attacks on its constitutional authority "to say what the law is." *Marbury*, 5 U.S. [1 Cranch.] at 177. As we explain below, the Act is an attempt by Congress to do exactly that.

II. CONGRESS PASSED THE ACT IN AN INTENTIONAL EFFORT TO OVERRULE *STENBERG*.

The Court in *Stenberg* made plain that a ban on "partial-birth abortion" would only pass constitutional muster if it banned intact D & E while unmistakably preserving non-intact D & E; and if it contained a health exception. *Stenberg*, 530 U.S. at 939, 950 (O'Connor, J., concurring). The Government argues that Congress attempted to comply with *Stenberg* by drafting a definition of "partial-birth abortion" that bans only intact D & Es.

However, the Act's language and legislative history prove otherwise.

The simplest way for a legislature to ban intact D & E to the exclusion of all other abortion methods is to use the term "intact D & E" (or "D & X") in the statute and to track with precision the steps involved in performing that procedure. The Act's drafters did not take this approach despite their familiarity with the relevant medical terminology. *See supra* note 3; *see also* H.R. Rep. No. 108-58, 108th Cong., 1st Sess., at 4 n.5 (distinguishing D & E abortions from "partial-birth abortions"), *id.* at 14 (equating "partial-birth abortions" with "D & X abortions"); 149 Cong. Rec. S3480 (daily ed. March 11, 2003) (describing the medical steps involved in performing an intact D & E). They also failed to include language that would allow a physician to perform a "partial-birth abortion" if the woman's health required it.

While the Act's language is different from prior congressional bills and the Nebraska statute invalidated in *Stenberg*, the differences are not constitutionally meaningful. Congress' pre-*Stenberg* bills, H.R. 3660 and S. 1692, defined "partial-birth abortion" as:

> an abortion in which the person performing the abortion deliberately and intentionally –
>
> (A) vaginally delivers some portion of an intact living fetus until the fetus is partially outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the fetus while the fetus is partially outside the body of the mother; and

> (B) performs the overt act that kills the fetus while the intact living fetus is partially outside the body of the mother.

See H.R. 3660, 106th Cong. (as passed by House, April 5, 2000); S. 1692, 106th Cong. (as passed by Senate, October 21, 1999); S. 1692, 106th Cong. (as passed by House, May 25, 2000).

The Nebraska statute defined "partial-birth abortion" as:

> deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child.

Neb. Rev. Stat. Ann. § 28-326(9) (Supp. 1999). The Act defines "partial-birth abortion" as:

> (A) deliberately and intentionally vaginally deliver[ing] a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and
>
> (B) perform[ing] the overt act, other than completion of delivery, that kills the partially delivered living fetus.

18 U.S.C. § 1531.

The Act suffers from exactly the same constitutional infirmities as the *Stenberg* statute: It does not define

"partial-birth abortion" in a manner that limits its reach to intact D & E; and it does not contain a health exception. As the Ninth Circuit explains, any non-intact D & E could proceed in a manner that violates the Act. Pet. App. 25a-26a ("Congress defined the prohibited procedure in a way that a number of doctors have explained includes both intact and non-intact D & E's, and that we likewise conclude bans both forms of the procedure."); *cf. Stenberg*, 530 U.S. at 940 ("we can find no difference, in terms of this statute, between the D & X procedure as described and the D & E procedure as it might be performed."). While Congress was not required to follow the Court's drafting suggestions in *Stenberg*, it *was* required to draft the Act in a manner that addressed the constitutional problems identified in that case. The sponsors' deliberate decision not to do so – over the clamorous objections of many of their colleagues (*see supra* note 4 and accompanying text) – is powerful evidence that they set out not to comply with *Stenberg* but to defy it.

The Act's legislative history supports the same conclusion. In rallying Congress to adopt the Act, the chief Senate sponsor railed not only at *Stenberg*, but *Casey*, *Roe v. Wade*, 410 U.S. 113 (1973), and even the concept of constitutionally-protected liberties:

> The Senator from Iowa read the famous clause out of the *Casey* decision, determining one's own concept of meaning of existence, of the universe, of the meaning of the universe, of the mystery of human life.
>
> * * * *
>
> I referred to the two killers from Columbine who said: I am the law. Where do you think they got that? Where do you think that came from? It

> came from the U.S. Supreme Court because that is what the Supreme Court says, that you are the law. You can define your own existence. You can define your own universe. That is the essential meaning of liberty. That wasn't in a dissenting opinion or a concurring. It was in the main body of [*Roe v. Wade*].
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> * * * *
>
> *Roe v. Wade* is, according to the Court, how they will decide abortion cases. I vehemently disagree with them and I will continue to fight on this floor and anywhere else I can to make sure that law, that Court decision taking the decision away from the American public – which is where it was prior to *Roe v. Wade* – taking the decision of great moral import away from the American public, is returned to the people.

149 Cong. Rec. S3645 (daily ed. March 12, 2003) (statement of Sen. Santorum); 149 Cong. Rec. S12943 (daily ed. October 21, 2003) (statement of Sen. Santorum).

Contrary to the Government's claim, the Ninth Circuit is not attempting to hold Congress to "impossible standards of draftsmanship." Pet. Br. 35. To suggest that Congress lacks the institutional competence to draft a statute that complies with *Stenberg* is absurd; indeed, one would be hard-pressed to imagine a simpler legislative task. If this Court were to strike down the Act, Congress could, if it wished, turn right around and enact a constitutional ban on intact D & E.

III. THE COURT SHOULD STRIKE DOWN THE ACT AS AN ATTEMPT TO USURP ITS CONSTITUTIONAL AUTHORITY.

While all three branches of the federal government are initially charged with interpreting the Constitution in the exercise of their duties, once this Court decides a constitutional question, its interpretation is authoritative and supreme. *City of Boerne v. Flores*, 521 U.S. at 535-37, *United States v. Nixon*, 418 U.S. 683, 703 (1974). *See generally* Larry Alexander & Frederick Schauer, *On Extrajudicial Constitutional Interpretation*, 110 Harv. L. Rev. 1359, 1377 (1997) ("When the Constitution is subject to multiple interpretations, a preconstitutional norm must referee among interpretations to decide what is to be done. One such norm is that the Supreme Court's interpretation is authoritative and supreme."). As Alexander & Schauer explain:

> The decision to create a single written constitution, and thus depart from a model of parliamentary supremacy, is based on the possibility of varying views about fundamental questions, and the undesirability of leaving their resolution to shifting political fortunes.
>
> * * * *
>
> [A]t times good institutional design requires norms that compel decisionmakers to defer to the judgments of others with which they disagree. Some call this positivism. Others call it formalism. We call it law.

Id. at 1376, 1387.

Official acts of defiance against the Supreme Court are most chilling where, as here, they involve attempts to

strip away politically unpopular constitutional rights. At such times the Court is the only force preventing unpopular rights and groups from falling prey to an "elective despotism:"

> An *elective despotism* was not the government we fought for; but one which should not only be founded on free principles, but in which the powers of government should be so divided and balanced among several bodies of magistracy, as that no one could transcend their legal limits, without being effectively checked and restrained by the others.

The Federalist No. 48 (James Madison) (emphasis in original). It is for this reason that cases like *Miranda*, *Johnson* and *Brown* hold such an important place in the history of our constitutional democracy. And it is why the Court's decisions in *Dickerson*, *Eichman* and *Cooper*, reaffirming the rights protected in those cases, are equally important.[6]

Imagine if the states refused to comply with the Court's ruling in *Miranda*, and instead insisted that the Fifth Amendment allowed the admission of confessions regardless of the officers' failure to advise the suspect of

---

[6] Separation of powers principles cut against the Court making any attempt to salvage the Act via a narrowing construction. The Government cites a number of cases that emphasize the wisdom of salvaging federal statutes whenever "possible." Pet. Br. 35-36. Whatever "possible" means, it surely *cannot* mean forcing a statutory interpretation plainly antithetical to congressional intent. As discussed in the Statement of the Case and section II, *supra*, the Act's language, findings and legislative history demonstrate that Congress *did not want* to limit the ban to intact D & E and *did not want* a health exception. The Court should not force a statutory construction that flies in the face of what Congress intended.

his constitutional rights. And imagine if, when federal courts issued writs of habeas corpus for the release of those prisoners, the states refused to comply, announcing, "Earl Warren has made his decision, now let him enforce it."

Imagine if, in the wake of *Romer v. Evans*, 517 U.S. 620 (1996), states across the country enacted statutes modeled after Colorado's Amendment 2, and refused to abide by federal court orders enjoining their enforcement. Or if, in the wake of *Lawrence v. Texas*, 539 U.S. 558 (2003), states continued to prosecute and imprison gay men and lesbians based on their private sexual conduct, and refused to honor federal writs ordering their release.

Imagine if, after the Eleventh Circuit decided *Schiavo ex rel. Schindler v. Schiavo*, 403 F.3d 1223 (11th Cir. 2005), and *Schiavo ex rel. Schindler v. Schiavo*, 403 F. 3d 1289 (11th Cir. 2005), *stay denied*, 544 U.S. 957 (2005), Florida Governor Jeb Bush sent in State troopers to seize Terry Schiavo, transport her to a hospital, and force doctors to restore her nutrition and hydration.

Worse yet, imagine if in the wake of *Bush v. Gore*, 531 U.S. 98 (2000), Vice President Gore had refused to recognize the legitimacy of the Court's ruling and urged his supporters to resist it. Or if Congress had refused on January 6, 2001, to certify the electoral votes of Florida on the ground that the results were constitutionally illegitimate absent the completion of a recount.

Our nation is at a point in its history when the need to preserve the rule of law is at a premium. The tension between law enforcement obligations and the need to protect the civil liberties of politically unpopular groups is particularly strong. It is times like these when each

branch must fulfill its constitutional duties with firm conviction. "'[T]here is no liberty, if the power of judging be not separated from the legislative, and executive powers.'" The Federalist No. 78 (Alexander Hamilton) (quoting Montesquieu). The Act is a bold attempt by Congress to wrest judicial power from the Court. It cannot stand.

CONCLUSION

For the reasons set forth above, the City asks the Court to strike down the Act in its entirety.

Respectfully submitted,

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In the Supreme Court of the United States

ALBERTO R. GONZALES, ATTORNEY GENERAL,
PETITIONER

v.

LEROY CARHART, ET AL.

ALBERTO R. GONZALES, ATTORNEY GENERAL,
PETITIONER

v.

PLANNED PARENTHOOD FEDERATION OF AMERICA,
INC., ET AL.

ON WRITS OF CERTIORARI
TO THE UNITED STATES COURTS OF APPEALS
FOR THE EIGHTH AND NINTH CIRCUITS

REPLY BRIEF FOR THE PETITIONER

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REPLY BRIEF FOR THE PETITIONER

Respondents' primary submission in these cases is that, in enacting the Partial-Birth Abortion Ban Act of 2003, Congress sought to overturn this Court's decision in *Stenberg* v. *Carhart*, 530 U.S. 914 (2000). The Act itself belies that submission. To the contrary, it is clear that, in devising the Act, Congress sought to comply with *Stenberg* and to remedy both of the constitutional deficiencies that this Court identified in *Stenberg*. First, Congress made detailed factual findings concerning the medical necessity of partial-birth abortion, and determined, based on those findings, that a statutory health exception was unnecessary. Second, Congress incorporated a narrower, more precise definition of partial-birth abortion, which was tailored to exclude the more common standard D&E abortion procedure. Congress's considered effort to meet the requirements of *Stenberg*, while exercising its well-established factfinding capabilities, in no way intrudes on the prerogatives of this Court, but instead represents a healthy exercise of the separation of powers.

For those reasons, and the reasons discussed in petitioner's opening briefs, *Stenberg* does not require invalidation of the Act, which denies no woman the ability to obtain a safe abortion and instead takes only the limited step of proscribing a rarely used and inhumane abortion procedure resembling infanticide. A contrary conclusion would have enormous implications for the ability of Congress to address an issue of grave medical and moral concern to most Americans. It would put courts in the difficult and institutionally problematic role of second-guessing congressional judgments about medical facts, and mark a return to the days in which abortion regulations—even those not preventing women from obtaining a safe abortion—were subject to the strictest of scrutiny. The invalidation of the Act would betray the lesson of the

joint opinion in *Planned Parenthood of Southeastern Pennsylvania* v. *Casey*, 505 U.S. 833 (1992), which rejected strict scrutiny and sanctioned various abortion regulations short of an outright ban. Moreover, acceptance of respondents' broader argument that partial-birth abortion is beyond regulation would betray *Stenberg* itself, which acknowledged that, as Justice O'Connor stressed in her concurring opinion, the inhumane and widely condemned practice of partial-birth abortion could constitutionally be prohibited in appropriate circumstances.

I. THE ABSENCE OF A HEALTH EXCEPTION DOES NOT RENDER THE ACT FACIALLY INVALID

A. *Stenberg* Did Not Adopt A Rule Of Virtual Per Se Invalidation For Abortion Regulations Lacking A Health Exception

Respondents in these cases urge the Court to read into *Stenberg* a rule of virtual per se invalidation for abortion regulations lacking a health exception. That proposed rule is inconsistent both with this Court's abortion precedents and with generally applicable principles of law.

Respondents contend that, under this Court's decision in *Stenberg*, it is sufficient for a plaintiff challenging a statute that lacks a health exception merely to point to "substantial medical authority" that suggests that the statute would create significant health risks (even if it would not prevent any woman from obtaining an abortion). See, *e.g.*, Carhart Br. 21-23; Planned Parenthood Br. 11-14. Respondents do not deny that, under their view, a plaintiff need not show that the preponderance of the evidence supports the proposition that the statute at issue would create significant health risks; instead, they concede only that a plaintiff must come forward with something more than "a lone expert, making bald assertions with no support." Carhart Br. 21.

Stenberg certainly does not purport to impose such a hair trigger for invalidating abortion regulations, and such an interpretation of *Stenberg* would effectively put that decision into conflict with the Court's earlier abortion decisions. Most notably, in *Casey*, the Court held only that it would be unconstitutional for the government to prohibit or restrict abortion where the regulation at issue would "interfere with a woman's choice to undergo an abortion procedure if continuing her pregnancy would constitute a threat to her health." 505 U.S. at 880. *Casey* considered the health risks from regulations that might delay an abortion and prolong a pregnancy, not the marginal health risks of two alternative abortion procedures in circumstances in which women would continue to have access to at least one safe procedure. But even in that context, *Casey* in no way indicated that the relevant constitutional inquiry was whether there was merely a *division of medical opinion* on the existence of a threat. Cf. *ibid.* (noting that it was "undisputed" that certain specified conditions could require an emergency abortion). Indeed, the joint opinion in *Casey* criticized the Court's earlier decision in *City of Akron* v. *Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983) (*Akron I*), for placing too much weight on the views of an individual physician when they deviated from the best judgment of the legislature. 505 U.S. at 881-887; see *Stenberg*, 530 U.S. at 969-970 (Kennedy, J., dissenting).

More broadly, respondents' standard—entitling them to judgment based on the testimony of competing experts—is antithetical to normal modes of procedure and ignores both the important countervailing government interests and the dramatic consequences of facial invalidation of a duly enacted statute. Merely identifying a dispute over a material fact is generally enough to survive a motion for summary judgment, not enough to prevail in a facial challenge. And a rule that allows the views of a minority of medical experts to trump the

considered views of Congress devalues the important government interests recognized in *Casey*. As the dissenters in *Stenberg* noted, such a rule would be tantamount to a requirement that every abortion regulation contain an express health exception, because "there will always be *some* support for a [banned] procedure and there will always be some doctors who conclude that the procedure is preferable." 530 U.S. at 1012 (opinion of Thomas, J.); see *id.* at 969 (opinion of Kennedy, J.) (noting that "[t]he standard of medical practice cannot depend on the individual views of [the plaintiff] and his supporters"). In *Stenberg*, the Court neither explicitly nor implicitly adopted such a per se rule. Under the analysis actually applied in *Stenberg*, the Act is clearly constitutional.[1]

B. When Analyzed Under The Proper Standard, The Record Overwhelmingly Supports Congress's Judgment That No Health Exception Was Required

1. Congress's Findings On The Medical Necessity Of Partial-Birth Abortion Are Entitled To Deference

Respondents do not seriously dispute the general proposition that courts should afford a high degree of deference to

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[1] Respondents do not attempt to defend the Ninth Circuit's holding that, under *Stenberg*, the appropriate *constitutional* inquiry is whether "there is a medical consensus that *no circumstance exists* in which the procedure would be necessary to preserve a woman's health." 05-1382 Pet. App. 15a (emphasis added). Even respondents seem to recognize the implausibility of such a rule, which in the facial challenge context would turn the applicable standard entirely on its head. Moreover, while respondents describe application of the "large fraction" standard for facial challenges applied to the spousal-notification provision at issue in *Casey* as "chillingly callous," Planned Parenthood Br. 13, nothing in *Stenberg* suggested that the Court was adopting a new, substantially more permissive rule for facial challenges, and there is nothing callous about requiring a plaintiff who seeks invalidation of a statute *in all its applications* to show that the statute is unconstitutional in all, or at least a large fraction, of those applications.

congressional factual findings that inform the constitutionality of federal statutes. See, *e.g.*, *Turner Broad. Sys., Inc.* v. *FCC*, 520 U.S. 180, 195 (1997) (*Turner II*). Instead, respondents offer a variety of arguments as to why Congress's findings here on the medical necessity of partial-birth abortion are not entitled to deference. Those arguments lack merit.

a. Respondents repeatedly contend that Congress was seeking to "circumvent the constitutional rule established in *Stenberg*," Planned Parenthood Br. 24, or to "alter the meaning and scope of substantive constitutional rights," Carhart Br. 24. Gongress's findings in the Act, however, do not take issue with the constitutional rule identified by this Court in *Stenberg*. Rather, Congress took that rule as its starting point and merely made findings relevant to that rule. See, *e.g.*, Act § 2(3), 117 Stat. 1201. Congress's findings—including its ultimate and most relevant finding that it is never medically necessary for a mother to undergo a partial-birth abortion—certainly bear on the application of the constitutional test articulated by this Court in *Stenberg*. But Congress's unobjectionable effort to comply with this Court's precedents is a far cry from an effort to defy those precedents. These cases are thus readily distinguishable from cases in which Congress sought to alter the constitutional rule of decision laid down by this Court, see *Dickerson* v. *United States*, 530 U.S. 428 (2000); sought to replace a constitutional ruling of this Court with a different substantive rule of decision under Section 5 of the Fourteenth Amendment, see, *e.g.*, *City of Boerne* v. *Flores*, 521 U.S. 507 (1997); or made findings that were insufficient as a matter of law to sustain Congress's exercise of a constitutional power, see *United States* v. *Morrison*, 529 U.S. 598 (2000).[2]

[2] Respondents and their amici repeatedly note that some supporters of the Act made statements critical of the Court's decision in *Stenberg*. See, *e.g.*, Carhart Br. 1; Fifty-Two Members of Congress Br. 2, 4. But the views of

Respondents suggest that "[e]xtension of * * * deference to this case would effectively provide Congress with carte blanche to violate the Constitution simply by making carefully chosen 'findings.'" Carhart Br. 24. Respondents, however, simply overlook the fact that, while congressional factual findings are entitled to substantial deference, see *Turner II*, 520 U.S. at 195, that deference does not amount to a blank check. Where Congress's findings are plainly not supported by substantial evidence, or where Congress's findings amount to legal conclusions, courts remain free to disregard those findings. See *ibid.*; *Lamprecht* v. *FCC*, 958 F.2d 382, 392 n.2 (D.C. Cir. 1992) (Thomas, Circuit Justice) (rejecting proposition that "a legislature could make a statute constitutional simply by 'finding' that black is white or freedom, slavery").

b. In a similar vein, respondents suggest that Congress was foreclosed from "making contradictory findings" to those made in the *Stenberg* litigation. Carhart Br. 31. But it is unclear exactly which argument respondents embrace. Respondents appear reluctant to defend the Eighth Circuit's conclusion that, because the medical necessity of partial-birth abortion was a "legislative" fact, *Stenberg* foreclosed Congress from making findings on that question (except on the basis of new evidence). See 05-380 Pet. App. 16a-20a. That reluctance is understandable. Deference to Congress's superior fact-finding function is appropriate precisely for such "legislative" facts, and, in any event, there is little evidence to support the premise that, in *Stenberg*, this Court was making "legislative" factual findings of its own. To the contrary, the Court repeatedly relied on the evidence presented to, and the factual find-

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individual legislators concerning the relative merits of this Court's precedents hardly taint their votes or undermine legislative efforts to comply with decisions with which some members may disagree. Moreover, the relevant focus is on the findings *of Congress*, not the views of individual legislators.

ings made by, the district court. See, *e.g.*, *Stenberg*, 530 U.S. at 931-932, 934, 936-937.

It cannot be that the case-specific factual findings of a single district judge, even when reviewed under an appropriately deferential standard by this Court, somehow foreclose Congress from making its own, truly "legislative" factual findings, based both on its superior institutional capacity to make such findings and, in this instance, on a fuller and updated evidentiary record. See Act § 2(5), 117 Stat. 1202.[3] Such a rule would effectively convert the Judiciary's power "to say what the law is," *Marbury* v. *Madison*, 5 U.S. (1 Cranch) 137, 177 (1803), into a power to say what the law *and facts* are, even when those facts pertain to an appropriate subject of legislation. Nothing in our Constitution or this Court's precedents supports that view. Instead, the Legislative Branch is plainly authorized to engage in its own factfinding, and is the branch best situated to collect the full range of relevant data and evaluate it from a broad spectrum of perspectives. Congress

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[3] Respondents repeatedly contend that Congress's factual findings should not receive deference because Congress made those findings based on "virtually the same factual record that informed this Court's decision in *Stenberg*." Carhart Br. 15; see *id.* at 19 & n.12; Planned Parenthood Br. 4-5 & n.6. Even if it were true that Congress did not consider any new evidence, Congress would not be foreclosed from revisiting the factual findings made by the district judge in *Stenberg* and making contrary findings of its own. Deference to congressional factual findings is based not just on Congress's superior capacity to root out raw data, but also on its ability to analyze that data more thoroughly and through the perspectives of elected officials representing diverse views and constituents across the Nation. See p. 10, *infra*. In any event, Congress did consider additional evidence in making its findings. Specifically, Congress held two post-*Stenberg* hearings in which it heard testimony from two physicians, Dr. Kathi Aultman and Dr. Mark Neerhof, who had not previously testified, see 05-1382 C.A. E.R. 578-586, 604, 862-866; heard testimony from a third physician, Dr. Curtis Cook, who had previously testified but on different topics, compare *id.* at 597-618 (2002 testimony) with *id.* at 544-546, 550-551 (1997 testimony); and received new documentary evidence.

does not lose that authority just because a court makes factual findings first in a particular case. Just as an agency does not lose its ability to resolve statutory ambiguities because a court construed the statute before an authoritative agency construction, see *National Cable & Telecomms. Ass'n* v. *Brand X Internet Servs.*, 125 S. Ct. 2688, 2700-2702 (2005), Congress does not lose its ability to find facts and legislate because of prior litigation.

c. Respondents contend that, even if courts should generally afford a high degree of deference to congressional factual findings, they should not do so "where the case requires the application of heightened scrutiny to violations of fundamental substantive rights." Carhart Br. 29. In *Turner II*, however, this Court deferred to Congress's express finding that statutory provisions requiring cable-television systems to carry local stations were necessary to preserve those stations in upholding those provisions under the First Amendment, applying the heightened (intermediate) scrutiny afforded to content-neutral regulations. See 520 U.S. at 196. Similarly, in *Board of Education* v. *Mergens*, 496 U.S. 226 (1990), a plurality of the Court (in reasoning with which none of the other Justices directly disagreed) deferred to Congress's finding that high school students were unlikely to confuse an equal-access policy with state sponsorship of religion in concluding that the Equal Access Act did not have the primary effect of advancing religion (and was thus valid under the Establishment Clause). See *id.* at 251. Those cases confirm that the degree of deference owed to congressional findings does not turn on the right at issue or the applicable level of scrutiny.[4]

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[4] In contending that congressional findings are not entitled to deference where heightened scrutiny is involved, respondents primarily rely on this Court's decisions in four First Amendment cases: *Landmark Communications, Inc.* v. *Virginia*, 435 U.S. 829 (1978); *Sable Communications of California, Inc.* v. *FCC*, 492 U.S. 115 (1989); *Ashcroft* v. *Free Speech Coalition*,

d. Finally, respondents contend that Congress's findings concerning the medical necessity of partial-birth abortion are not entitled to deference because Congress has no particular institutional expertise in that area. See, *e.g.*, Carhart Br. 31-32. Congress, however, has long exercised its authority under the Commerce Clause to regulate various aspects of medical practice—whether directly through its regulation of the sale, composition, and labeling of drugs (and the use of medical devices), see Federal Food, Drug & Cosmetic Act, 21 U.S.C. 301 *et seq.*; Controlled Substances Act, 21 U.S.C. 801 *et seq.*, or indirectly through its provision of funding for various types of medical expenses, see Social Security Act, 42 U.S.C. 301 *et*

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535 U.S. 234 (2002); and *Randall* v. *Sorrell*, 126 S. Ct. 2479 (2006). In *Landmark*, however, this Court merely refused to defer to a *state* legislature's essentially legal conclusion that the divulgence of confidential information would pose a clear and present danger to the orderly administration of justice. See 435 U.S. at 843. In *Sable*, the Court rejected a request for deference on the ground that "the congressional record contain[ed] no legislative findings" pertinent to the constitutional question presented. See 492 U.S. at 129. *Landmark* and *Sable*, moreover, have since been cited only for the modest proposition that "[the fact] [t]hat Congress' predictive judgments are entitled to substantial deference does not mean * * * that they are insulated from meaningful judicial review altogether." *Turner Broad. Sys., Inc.* v. *FCC*, 512 U.S. 622, 666 (1994) (*Turner I*) (plurality opinion). In *Free Speech Coalition*, the Court did not explicitly refuse to defer to congressional findings at all (and, to the extent that it did so implicitly, did so only on the ground that any congressional findings were legally irrelevant). See, *e.g.*, 535 U.S. at 253, 254. Finally, in *Randall*, the plurality opinion concluded only that, while legislatures had considerable leeway to make "empirical judgments" with regard to campaign-finance regulations, courts were required to exercise "independent judicial judgment" when "assessing [a] statute's 'tailoring,' that is, * * * assessing the proportionality of the [statute's] restrictions." 126 S. Ct. at 2492. In the end, the Court's decision, on occasion, to reject a statute even under a deferential review of legislative factfinding does not amount to a determination that deference is inappropriate in the first place, any more than a conclusion that an agency's interpretation of an ambiguous statute is unreasonable would amount to a determination that deference to the agency is inappropriate.

seq. And this Court has repeatedly deferred to Congress's findings on legislation involving medical matters. See, *e.g.*, *Jones* v. *United States*, 463 U.S. 354, 363-366 & n.13 (1983); *Usery* v. *Turner Elkhorn Mining Co.*, 428 U.S. 1, 33-34 (1976); *Lambert* v. *Yellowley*, 272 U.S. 581, 588-597 (1926). In any event, the principle of deference to congressional factual findings does not turn on a court's assessment of Congress's true level of expertise regarding a particular subject, but is instead based more generally on Congress's superior institutional ability to "amass and evaluate * * * data bearing upon legislative questions," *Turner II*, 520 U.S. at 195 (internal quotation marks omitted), as well as its constitutional responsibility to "weigh[] conflicting evidence in the legislative process," *id.* at 199. That capability surely exceeds the factfinding powers of a single district judge.

2. *Congress's Findings Are Supported By Substantial Evidence*

Respondents prefer to focus on subsidiary findings and mistaken arguments that Congress's findings here do not enjoy the normal deference, rather than making a serious effort to challenge Congress's ultimate and most relevant finding that "partial-birth abortion is never medically indicated to preserve the health of the mother," Act § 2(14)(O), 117 Stat. 1206, under the deferential standard set out in *Turner II*. To the extent that respondents do take issue with Congress's ultimate finding, their effort to undermine it is unavailing.

a. Respondents primarily rely on the district courts' findings in their respective cases that substantial medical authority supported the proposition that partial-birth abortion was sometimes medically necessary, contending that those findings are entitled to deference (and indeed are reviewable only for clear error). See, *e.g.*, Carhart Br. 2-3, 5, 21-23; Planned

Parenthood Br. 14-24. That contention is erroneous, however, both because it misapprehends the applicable legal standard, see pp. 2-4, *supra*, and because it turns well-established principles concerning Congress's superior factfinding capacity on their head. The constitutionality of nationwide legislation properly depends on the credibility judgments of Congress, not those of individual district court judges, which of course can vary. And deference to congressional factfinding does not become inapplicable simply because a district court hears witnesses who did not testify before Congress.[5]

b. To the extent that respondents attempt to come to terms with Congress's factual findings, they primarily attack Congress's *subsidiary* findings. See, *e.g.*, Planned Parenthood Br. 26-29. The relevant legal question before this Court, however, is not whether *all* of Congress's findings, including those that do not bear directly on the underlying legal question, are supported by substantial evidence. Instead, it is whether substantial evidence supports Congress's *ultimate*, and most relevant, finding that "partial-birth abortion is never medically indicated to preserve the health of the mother." Act § 2(14)(O), 117 Stat. 1206. By focusing on Congress's other findings, respondents commit the same error as the courts below, which (based on their misreading of *Stenberg*) asked only whether substantial evidence supported the proposition that there is no division of opinion as to whether partial-birth abortion is medically necessary in some

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[5] Where a reviewing court has before it evidence that was not before Congress, it can consider that evidence in engaging in "substantial evidence" review. See *Turner II*, 520 U.S. at 195. The relevant question, however, is not whether the reviewing court would reach the same determination as Congress based on the record as supplemented; instead, it is whether there is sufficient evidence to suggest that Congress's determination was reasonable in the first place. See, *e.g.*, *id.* at 210-211; *Rostker* v. *Goldberg*, 453 U.S. 57, 82-83 (1981).

circumstances. See, *e.g.*, 05-380 Pet. App. 460a-461a; 05-1382 Pet. App. 15a.

c. Substantial evidence supports Congress's key findings, including its ultimate finding concerning the medical necessity of partial-birth abortion. The starting point for the "substantial evidence" inquiry is the evidence that was actually before Congress when it made its findings. As petitioner's opening briefs in these cases explain, numerous physicians who appeared before Congress testified that there were no circumstances in which partial-birth abortion was the only appropriate type of abortion; that partial-birth abortion offers no safety advantages over other types of abortion; and that partial-birth abortion presents various safety risks that other abortion procedures do not. 05-380 Br. 31-33; 05-1382 Br. 22. Respondents' only answer to that testimony is the unelaborated assertion that "[n]one of th[o]se physicians are experts in second-trimester surgical abortion, and several, if not all, oppose abortion by any method." Planned Parenthood Br. 29 n.24. That does not suffice.

While it is true (and unsurprising) that none of the physicians who believed that the partial-birth abortion procedure was unnecessary and posed health risks had ever personally performed such an abortion, all of those physicians were experienced obstetricians, and some were maternal-fetal experts who specialized in treating women with high-risk pregnancies (and therefore could readily assess the risks that would attend particular types of abortion procedures). And while at least some of those physicians may be opposed to abortion more generally, it does not follow that those physicians would be biased in their assessment of the *comparative* risks presented by different abortion methods. Because Congress could readily have concluded that those physicians were credible witnesses, there is no basis for discounting their testimony in assessing the validity of Congress's findings.

Congress's findings concerning the medical necessity of partial-birth abortion, moreover, were supported not only by the testimony of those physicians who testified before Congress, but also by (1) other evidence in the legislative record, including statements from leading physician groups, articles in medical journals, and written statements from other physicians, and (2) the testimony of still other physicians in the trials in these cases. See 05-380 Pet. Br. 33-37; 05-1382 Pet. Br. 22-24. Respondents merely challenge selected pieces of that evidence, not the substantiality of the record as a whole, and their specific challenges in any event lack merit.

With regard to the other evidence in the legislative record, respondents suggest that the American Medical Association (AMA) and the American College of Obstetricians and Gynecologists (ACOG) actually held the view that partial-birth abortion was sometimes medically necessary. See, *e.g.*, Carhart Br. 34-35. Notwithstanding its ultimate decision to oppose the Act, however, the AMA repeatedly expressed the view that partial-birth abortion is never the only appropriate procedure to protect a woman's health. See 05-380 Pet. C.A. App. 758, 775, 1002, 1004. And while a select panel convened by ACOG did suggest that partial-birth abortion could in some circumstances be the "best" choice, it ultimately concluded that it "could identify no circumstances under which [partial-birth abortion] would be the only option to save the life or preserve the health of the woman." See 05-1382 J.A. 856-857, 860; 05-380 Pet. C.A. App. 1056, 1297. Consistent with those views, no one suggests that a doctor who refuses to perform a D&X abortion, but instead employs only the standard D&E procedure, is committing malpractice or operating outside the accepted standards of medical practice. There is therefore no bar to the legislature making the same judgment that any doctor can safely and responsibly make—to rule out the D&X procedure.

With regard to the trial testimony in these cases, respondents note that the district courts credited the testimony of their experts over the testimony of the government's. See, *e.g.*, Planned Parenthood Br. 7-8, 15-16. Even assuming the validity of those credibility determinations—and there is good reason to question them, see 05-1382 Pet. Br. 25-27—the credibility judgments of individual district court judges cannot trump the credibility judgments of Congress.[6]

d. Respondents heavily rely on the evidence they presented at trial, which in their view shows that partial-birth abortion is safer than other types of abortion either in specific circumstances or as a more categorical matter. The whole point of "substantial evidence" review, however, is that a reviewing court is required to defer to congressional findings even if the evidence is in conflict (and more than one conclusion could thus be drawn from that evidence). See, *e.g.*, *Turner II*, 520 U.S. at 208, 210. To the extent that the lower courts in these cases found that there was a division of opinion on the medical necessity of partial-birth abortion, see, *e.g.*, 05-380 Pet. App. 463a; 05-1382 Pet. App. 22a, 215a, the necessary implication is that there was, at least, *substantial evidence* to support Congress's finding that partial-birth abortion is never medically indicated.

In any event, the better view, based on the evidence in all three of the cases challenging the constitutionality of the Act,

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[6] Respondents contend that the government's own experts recognized that "the hypothesized risks of [partial-birth abortion] are overstated or speculative." Planned Parenthood Br. 19. Notwithstanding some isolated statements to the contrary, however, the trial and congressional records are replete with statements that partial-birth abortion carries greater risks of cervical incompetence, see, *e.g.*, 05-1382 J.A. 653-655, 776-779, 881; 05-1382 C.A. E.R. 145, 545, 579-580, 970, and hemorrhaging and infection, see, *e.g.*, 05-1382 J.A. 660-662, 938, 1013-1016; 05-1382 C.A. E.R. 145-146, 863, 971, and poses additional risks from the internal rotation of the fetus to a feet-first position, see, *e.g.*, 05-1382 J.A. 657-660, 937-938; 05-1382 C.A. E.R. 146, 545, 863.

is that partial-birth abortion is not safer than other types of abortion either generally or in any specific circumstance. With regard to safety generally, one of the district courts to have considered the issue found that "the Government's expert witnesses reasonably and effectively refuted Plaintiffs' proffered bases for the opinion that D&X has safety advantages over other second-trimester abortion procedures," and that "many of Plaintiffs' purported reasons for why D&X is medically necessary" are either only "theoretical" or simply "false." *National Abortion Fed'n* v. *Ashcroft*, 330 F. Supp. 2d 436, 479, 480 (S.D.N.Y. 2004), aff'd, 437 F.3d 278 (2d Cir. 2006) (*NAF*). While the plaintiffs in these cases have claimed that partial-birth abortions are generally safer than standard D&E abortions because partial-birth abortions present a lower risk of (1) cervical or uterine trauma, (2) retained fetal parts, (3) laceration from bony fragments, and (4) hemorrhage or infection, evidence presented at the trials suggested that each of those asserted safety benefits was hypothetical at best.[7] In response, respondents presented only anecdotal evidence and intuition, and no scientific evidence, to support their claims. While respondents relied on a peer-reviewed study led by a plaintiff in another of the three cases, Dr. Stephen Chasen, and based on abortions performed by Dr. Chasen and one of his partners, that study concludes that partial-birth abortion and standard D&E abortion had no significant differences in short-term complication rates, blood

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[7] See, *e.g.*, 05-1382 J.A. 148, 322, 880, 957-958 (risk of cervical or uterine trauma in standard D&E abortions was minimized by the use of smooth, rounded forceps and standard ultrasound techniques); *id.* at 148, 319-320 (risk of retained fetal parts was minimized by the use of ultrasound and by inspection of the uterus and inventory of removed parts); *id.* at 374 (risk of bony fragments was minimized by proper use of forceps); 05-380 J.A. 480, 484 (risk of hemorrhage or infection was the same in partial-birth abortion and standard D&E abortion because both result in similar blood loss).

loss, or procedure time[8]—and actually documents (albeit below a level deemed statistically robust) that the D&X procedure resulted in a higher rate of subsequent premature birth. 05-380 J.A. 479-494, 615-617; 05-380 Pet. C.A. App. 2114.[9]

With regard to safety in specific circumstances, the district court in *NAF* found that "[i]n no case * * * could Plaintiffs point to a specific patient or actual circumstance in which D&X was necessary to protect a woman's health." 330 F. Supp. 2d at 480. Numerous experts, including several of respondents' own experts, testified that there was no particular circumstance in which partial-birth abortion was medically necessary. See, *e.g.*, 05-1382 J.A. 536, 938-939; 05-380 C.A. App. 1377. It should be emphasized, as well, that the relatively long lead time necessary for sufficient dilation makes the D&X procedure particularly ill-suited for dealing with emergency health issues when time is of the essence. While respondents list various medical conditions for which they believe partial-birth abortion would be the safest abortion method, see, *e.g.*, Carhart Br. 6-7; Planned Parenthood Br. 20-22, the district court in *Carhart* was the only one that agreed

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[8] Although respondents contend that the Chasen study shows that partial-birth abortion is in fact safer because the median gestational age for women undergoing partial-birth abortions was higher than for women undergoing standard D&E abortions, see Carhart Br. 10; Planned Parenthood Br. 19, the Chasen study merely concluded that the complication rates from the two types of procedure appeared to be similar, without making any claim concerning the implications of any difference in gestational age. See 05-1382 J.A. 534. Moreover, other factors, such as the higher average age of the women undergoing the standard D&E procedure, would seem to point in the opposite direction.

[9] In an amicus brief in these cases, Dr. Chasen (together with the other plaintiffs in *NAF*) cites a later article in which he and his co-authors attempt to explain the evidence concerning the higher rate of subsequent premature birth. Br. 13. That article, however, was not written until 2005 and is not contained in the trial record in any of the three cases.

with respondents, and it did so only with respect to two conditions: placental cancer (in combination with preeclampsia) and placenta previa. See 05-380 Pet. App. 481a-482a. The underlying evidence on which that court relied does not support respondents' claims with regard to either of those conditions. As to placental cancer, the court cited the testimony of only one physician, Dr. Joanna Cain—but she based her conclusion that partial-birth abortion was the safest abortion method for such cases solely on statements made in the deliberations of ACOG's task force, see 05-380 J.A. 500, which ultimately concluded that it "could identify no circumstances under which [partial-birth abortion] would be the only option to save the life or preserve the health of the woman." 05-1382 J.A. 856. As to placenta previa, the court primarily relied on the testimony of Dr. Cassing Hammond—but he testified only that a D&E abortion would be safer than a hysterotomy in cases involving that condition, not that the D&X procedure would be safer than a standard D&E procedure. See 05-380 J.A. 749-750.

At a minimum, respondents' trial evidence concerning the medical necessity of partial-birth abortion was not so overwhelming as to render Congress's factual findings unsupported by substantial evidence. Those findings are therefore valid and entitled to deference.

C. Even Assuming That Partial-Birth Abortion Has Marginal Health Advantages In Some Cases, A Statute That Prohibits Partial-Birth Abortion Does Not Impose An Undue Burden On A Woman's Access To An Abortion

Even if the Court refused to defer to Congress's factual findings, it should conclude that the Act would not impose an undue burden on a woman's access to an abortion. Respondents do not appear to contend that partial-birth abortion is necessary for the preservation of the mother's health in the

sense that, when a mother *requires* an abortion for a non-life-threatening health condition, partial-birth abortion will be her only safe or practical option. That is unsurprising, because two of the three district courts to have considered the issue have squarely found that the plaintiffs in those cases failed to identify any such situation. See 05-1382 Pet. App. 147a; *NAF*, 330 F. Supp. 2d at 480. Moreover, respondents appear to concede that standard D&E abortions are generally safe—and respondents' amici expressly make that concession. See, *e.g.*, AMWA Br. 14 (stating that D&E by dismemberment is "extremely safe"); Chasen Br. 20 (stating that complications from D&E are "fortunately[] rare"). That is also unsurprising, because respondents' experts repeatedly testified that they considered standard D&E abortions to be "very" or "extremely" safe. See, *e.g.*, 05-1382 J.A. 132, 237, 265, 409. And there is no suggestion that doctors who perform only D&E abortions are endangering their patients or deviating from the appropriate standard of care.

The relevant constitutional question in these cases is therefore whether it would impose an undue burden on any given woman's right to an abortion to prohibit an inhumane and rarely used type of partial-birth abortion procedure when that prohibition does not deny the woman a safe abortion, including a safe late-term abortion, by a more common procedure. The answer to that question is clearly no. The Act implicates not only the government's compelling interest in protecting human life, but also the government's specific (and no less compelling) interest in prohibiting a particular type of abortion procedure that closely resembles infanticide. See, *e.g.*, *Stenberg*, 530 U.S. at 960, 962 (Kennedy, J., dissenting) (concluding that "Nebraska's ban on partial birth abortion furthers purposes States are entitled to pursue" and that "Nebraska was entitled to find the existence of a consequential moral difference between the [D&X and D&E] procedures").

Respondents and their amici contend that the latter interest is not compelling, or even legitimate, because it constitutes merely a "moral" interest. Planned Parenthood Br. 31-32; AMWA Br. 27-29; NWLC Br. 2-3. That is both mistaken and beside the point. The line between being *in utero* and being outside the womb has long been the line that separates abortion from infanticide. A law that reinforces that line in the class of abortions that take place just before viability clearly promotes the government's interest in protecting life. But even if the government's interest in avoiding the slippery slope to infanticide is somehow categorically different from the interest in protecting life, but cf. *Washington* v. *Glucksberg*, 521 U.S. 702, 728-735 (1997), the interest in promoting life could similarly be described as a moral interest. That interest, however, was described in the joint opinion in *Casey* as "substantial," "profound," and "important," see, *e.g.*, 505 U.S. at 871, 876, 878, and is the interest that underpins all of the government's valid abortion regulations. If the government was foreclosed from relying on "moral" interests in regulating abortion, it would be largely disabled not just from regulating late-term abortion procedures such as partial-birth abortion, but from regulating abortion altogether. That position is sharply at odds with the joint opinion in *Casey*, which emphasized that the "the State's important and legitimate interest in potential life * * * has been given too little acknowledgment." *Id.* at 871 (citation omitted).

D. To The Extent That The Court Believes That *Stenberg* Compels A Different Result, It Should Be Overruled

For the reasons explained above and in petitioner's opening briefs, the Court's decision in *Stenberg* is not controlling. If, however, the Court were to conclude that its decision in *Stenberg* compels the conclusion that the Act is unconstitutional, then *Stenberg* should be overruled.

As this Court has explained, "*[s]tare decisis* is the preferred course because it promotes the evenhanded, predictable, and consistent development of legal principles, fosters reliance on judicial decisions, and contributes to the actual and perceived integrity of the judicial process." *Payne* v. *Tennessee*, 501 U.S. 808, 827 (1991). Particularly in constitutional cases, however, it is "common wisdom" that stare decisis is not an "inexorable command." *Casey*, 505 U.S. at 854. Contrary to respondents' arguments (Carhart Br. 35-37; Planned Parenthood Br. 29-31), several considerations weigh strongly against affording stare decisis effect to *Stenberg*.

As a preliminary matter, *Stenberg* is a recent and deeply divided decision that this Court has not followed in any other cases. *Stenberg* was grounded on a reading of another 5-4 decision, *Casey*, and was sharply criticized by one of the Justices in the *Casey* majority as an unjustified departure from that decision. See *Stenberg*, 530 U.S. at 956-957, 979 (Kennedy, J., dissenting). Even in the short time since its issuance, moreover, *Stenberg* has already proven to be unworkable in practice, as reflected in the different analytical approaches taken in the lower-court opinions that have attempted to apply it. This is true not only of courts considering the constitutionality of the Act, but also of courts considering the validity of other abortion regulations, which have reached conflicting conclusions as to, *inter alia*, whether *Stenberg* requires every abortion regulation to contain an express health exception and, if not, what evidentiary showing must be made before such an exception is required. See, *e.g.*, *Richmond Med. Ctr. for Women* v. *Hicks*, 409 F.3d 619, 622, 625-626 (4th Cir. 2005), petition for cert. pending, No. 05-730 (filed Dec. 1, 2005); *Women's Med. Prof. Corp.* v. *Taft*, 353 F.3d 436, 448 (6th Cir. 2003); *A Woman's Choice—East Side Women's Clinic* v. *Newman*, 305 F.3d 684, 688 (7th Cir. 2002), cert. denied, 537 U.S. 1192 (2003).

Moreover, if *Stenberg* really requires courts to engage in extensive evidentiary proceedings to second-guess congressional judgments about medicine, then it has proven unworkable by thrusting courts into a role for which they are institutionally ill-suited. It is one thing to require courts to ensure that Congress had substantial evidence, but it is quite another matter to force courts to engage in extensive factfinding to determine whether there is a sufficient consensus of medical opinion. This Court observed over a century ago that "[i]t is no part of the function of a court or a jury to determine," when medical opinion is divided, "which one of two modes was likely to be most effective for the protection of the public against disease." *Jacobson* v. *Massachusetts*, 197 U.S. 11, 30 (1905). Federal courts "are ill-equipped to evaluate the relative worth of particular surgical procedures," *Stenberg*, 530 U.S. at 968 (Kennedy, J., dissenting), and cannot sit as "the Nation's *ex officio* medical board[s]," *ibid.* (quoting *Akron I*, 462 U.S. at 456 (O'Connor, J., dissenting)).

Overruling *Stenberg* would not affect any relevant reliance interests, because it could hardly be said that "people have organized intimate relationships and made choices that define their views of themselves and their places in society[] in reliance on the availability" of the gruesome and rarely used procedure of partial-birth abortion. *Casey*, 505 U.S. at 856. Moreover, there could be no *reasonable* reliance on *Stenberg* here, because the extension of *Stenberg* that respondents seek would put it in conflict with numerous other decisions of this Court: most notably, but by no means limited to, the Court's decision in *Casey*. See *Stenberg*, 530 U.S. at 957, 960-963, 979 (Kennedy, J., dissenting); *id.* at 1005-1020 (Thomas, J., dissenting). Such a reading would mark a return to the strict scrutiny expressly abandoned in *Casey*; would extend that strict scrutiny to legislative judgments concerning health, despite a century of precedents employing a much more def-

erential analysis, see, *e.g.*, *Kansas* v. *Hendricks*, 521 U.S. 346, 360 n.3 (1997); *Jacobson*, 197 U.S. at 30; and would resurrect the *Akron I* requirement of near-absolute deference to the treating physician, which was overruled by the joint opinion in *Casey*, see 505 U.S. at 881-887. If *Stenberg* must be read to require a choice between *Stenberg* and all these other precedents of the Court, the Court should jettison *Stenberg* and preserve the latter.

II. THE ACT IS NEITHER UNCONSTITUTIONALLY OVERBROAD NOR UNCONSTITUTIONALLY VAGUE

A. The Act Is Not Unconstitutionally Overbroad

1. Unlike the statute in *Stenberg*, the Act defines "partial-birth abortion" in a way that unambiguously does not reach standard D&E abortions. The Act applies only where a physician "deliberately and intentionally vaginally delivers a living fetus" past a specified anatomical "landmark" and then "performs [an] overt act, other than completion of delivery, that kills the partially delivered living fetus"—and delivers the fetus with the purpose of performing that overt act. The Act thus excludes standard D&E abortions, in which the dismemberment of the fetus is not a discrete act from the delivery of a portion of the fetus and in which a major portion of the fetus is usually not delivered while the fetus is still living.

2. Respondents contend that, in a standard D&E abortion, a physician would like to deliver the fetus as intact as possible, and that, where the physician is able to remove most of the fetus but is unable to remove the fetus intact (*e.g.*, because the head becomes stuck), the physician must sometimes perform a partial-birth abortion instead (*e.g.*, by puncturing the fetus's skull and vacuuming out its brain). Carhart Br. 42-43; Planned Parenthood Br. 34-37. Indeed, the Planned Parenthood respondents go even further and make the novel suggestion that partial-birth abortion does not even exist as a dis-

crete procedure, because physicians always set out to remove as much of the fetus as possible. Br. 41. Under that view, D&X is not a distinct procedure, only a particularly "successful" variant of the D&E procedure. That suggestion, however, cannot be squared with the history of the partial-birth abortion procedure, which makes clear that partial-birth abortion was developed as a distinct type of procedure in which the physician intentionally seeks to achieve a greater degree of dilation than in a standard D&E abortion, for the specific purpose of removing the fetus intact. See *Stenberg*, 530 U.S. at 927-928; *id.* at 959-960 (Kennedy, J., dissenting); *id.* at 985-989 (Thomas, J., dissenting); cf. AMWA Br. 15 (noting that, in initially explaining the procedure of partial-birth abortion, the procedure's inventor "described both dilation techniques and intra-operative techniques used to maximize the possibility of intact removal"). That suggestion also defies the analysis of *Stenberg*, which faulted the Nebraska statute for failing to distinguish clearly between the D&X and D&E procedures (which would hardly be a failing if no meaningful difference existed). It likewise defies the innumerable references in the congressional and lower-court records to D&X and D&E as distinct procedures. Finally, that suggestion squarely conflicts with this Court's promise in *Stenberg* that a properly drawn statute could distinguish between D&X and D&E and validly regulate the former.[10]

3. Respondents contend that the Act is overbroad because it in fact reaches standard D&E abortions in which a physi-

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[10] It is undoubtedly true that partial-birth abortions are much rarer than standard D&E abortions. See, *e.g.*, *Stenberg*, 530 U.S. at 924-927, 929. But that does not mean they cannot be regulated. See *id.* at 964 (Kennedy, J., dissenting) ("It ill-serves the Court, its institutional position, and the constitutional sources it seeks to invoke to refuse to issue a forthright affirmation of Nebraska's right to declare that critical moral differences exist between the two procedures.").

cian does not set out to perform a partial-birth abortion, but ends up having to perform one anyway (and that the Act would therefore chill physicians from *ever* performing standard D&E abortions). Carhart Br. 44-45; Planned Parenthood Br. 42-44. In such cases, however, the physician would lack the required intent to be covered by the Act: *i.e.*, the specific intent, at the outset of the procedure, to deliver the requisite portion of the fetus for the purpose of performing the ultimate lethal act. Contrary to respondents' contentions, that interpretation is compelled by the text of the Act itself, which applies only where the person performing the abortion "deliberately and intentionally" delivers the requisite portion of the fetus "for the purpose" of performing the ultimate lethal act. It is clear from that compound mens rea requirement that the physician must have the "purpose" of performing the ultimate lethal act *at the outset of the procedure*—not that it is sufficient for the physician to *develop* that "purpose" once the procedure is underway. See 05-380 Pet. Br. 47-48; 05-1382 Pet. Br. 32-33. Where a physician originally intends to perform a standard D&E abortion, therefore, the physician will not be subject to the Act.

4. The Carhart respondents repeatedly contend that the Act "ban[s] some non-intact D&Es" because it would reach abortions in which a physician delivers the requisite portion of the fetus and only then performs a discrete act of dismemberment (and delivers the fetus with the purpose of performing that act). Br. 38; see Br. 2, 17, 41-42. The Planned Parenthood respondents, however, concede that there is no evidence that physicians ever perform such delivery-followed-by-dismemberment abortions. See Br. 41 n.34. And even if they did, there is no sense in which such abortions could be classified as *standard* D&E abortions; instead, such abortions are simply partial-birth abortions that are effectuated in a particularly gruesome manner. Because the Act does not reach any

standard D&E abortions, and because the Act does not reach partial-birth abortions carried out by physicians who had intended to perform standard D&E abortions instead, it is not unconstitutionally overbroad.

B. The Act Is Not Unconstitutionally Vague

1. Respondents renew their contention that the operative provisions of the Act more generally are unconstitutionally vague. Carhart Br. 45-47; Planned Parenthood Br. 44-47. As has already been shown, however, that contention fails because the Act unambiguously excludes standard D&E abortions (and, at a minimum, could reasonably be so construed), and otherwise precisely defines the conduct that it prohibits. The Carhart respondents do not contend that any specific phrases *within* the Act are impermissibly vague. While the Planned Parenthood respondents challenge the Act's use of the phrase "overt act," Br. 45, their real complaint is with the *breadth* of that phrase, rather than with its clarity. The phrase "overt act" plainly refers to any act distinct from the act of delivery, other than the "completion of delivery"—a statutory exception that is designed to exclude induction abortions. The phrase "overt act" is broad in reach precisely in order to ensure that a physician cannot evade the Act simply by performing an atypical lethal act: *e.g.*, by dismembering the partially delivered fetus, rather than crushing its skull. There is nothing vague about the phrase "overt act," or, for that matter, any other term or phrase in the statute.[11]

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[11] Amicus California Medical Association contends that the phrase "in or affecting * * * commerce" is impermissibly vague. Br. 4-18. As a preliminary matter, the plaintiffs in all three cases conspicuously failed to argue that the Act constituted an impermissible exercise of Congress's Commerce Clause authority—nor would such a challenge be likely to succeed, as CMA appears to recognize. See, *e.g.*, Br. 6-7 (discussing Freedom of Access to Clinic Entrances Act of 1994, 18 U.S.C. 248). CMA's derivative vagueness argument is meritless, because the phrase "in or affecting * * * commerce" unambigu-

2. With regard both to the Act's asserted overbreadth and to its asserted vagueness, respondents fail to suggest any way in which Congress could have drafted the Act to remedy the alleged constitutional deficiencies. Indeed, respondents virtually acknowledge that, in their view, Congress could not draft *any* statutory language—including a ban on the D&X procedure, in terms—that would effectively regulate partial-birth abortion while navigating the Scylla and Charybdis of overbreadth and vagueness. See, *e.g.*, Carhart Br. 47 n.29. If, for example, Congress sought to address the Act's asserted overbreadth by passing a less specific statute that simply prohibited "partial-birth" abortions (or "D&X" or "intact D&E" abortions), respondents would undoubtedly argue that the statute was unconstitutionally vague—and indeed, insofar as they believe that partial-birth abortions and standard D&E abortions are not meaningfully distinct, would likely argue that the statute is still overbroad. If, on the other hand, Congress sought to address the Act's asserted vagueness by passing a statute that contained a different definition of "partial-birth abortion" (*e.g.*, by prohibiting only the "crushing of the fetus's skull," rather than an "overt act[] other than completion of delivery"), the resulting statute could readily be circumvented. At bottom, respondents' approach is irreconcilable with the position of a majority of this Court in *Stenberg*: namely, that a valid statute could be drafted to prohibit partial-birth abortion. See, *e.g.*, 530 U.S. at 951 (O'Connor, J., concurring).

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ously modifies the phrase "performs a partial-birth abortion," and the Act thus regulates partial-birth abortions to the full extent of Congress's Commerce Clause authority. See, *e.g.*, *United States* v. *Carter*, 981 F.2d 645, 646-647 (2d Cir. 1992) (rejecting similar vagueness challenge to 18 U.S.C. 922(g)).

C. The Court May Construe The Act To Avoid Any Conceivable Overbreadth Or Vagueness Deficiency

When it comes to respondents' overbreadth and vagueness arguments, these cases differ from *Stenberg* in another critical respect. Because these cases involve the interpretation of a federal statute, rather than a state statute, the Court may and, if it deems it necessary to do so, should construe the Act to avoid any constitutional deficiencies it might identify. For example, respondents' own arguments as to how a delivery-and-dismemberment procedure would not constitute a D&X amply justify Congress's decision to avoid that medical term in its prohibition. Cf. *Hendricks*, 521 U.S. at 359 (noting that "[l]egal definitions * * * need not mirror those advanced by the medical profession"). But if the Constitution requires the statute to prohibit the D&X procedure as such, the Act can readily be so construed. More broadly, as long as the Court applies the normal canons of constitutional avoidance, rather than the "canon of construction under which in cases involving abortion, a permissible reading of a statute is to be avoided at all costs," *Thornburgh* v. *American Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 829 (1986) (O'Connor, J., dissenting) (internal quotation marks and citation omitted), there is no obstacle to construing the statute to avoid constitutional difficulty.

III. IF THE COURT HOLDS THE ACT UNCONSTITUTIONAL, IT MAY BE ABLE TO FASHION A NARROWER REMEDY THAN FACIAL INVALIDATION

Respondents also err in arguing that the Act must be invalidated in its entirety if the Court concludes it may be unconstitutional in *any* application.

1. As a preliminary matter, the Planned Parenthood respondents suggest that, in determining whether narrower injunctive relief is appropriate, a reviewing court should em-

ploy a presumption in favor of facial invalidation (and against narrower injunctive relief), on the ground that "Congress can always follow the Court's guidance and re-enact a law that conforms to the Constitution." Br. 48 n.38. But that suggestion is flatly inconsistent with this Court's decision in *Ayotte* v. *Planned Parenthood of Northern New England*, 126 S. Ct. 961 (2006), which made clear that the "normal rule" is to enjoin a statute only as to its unconstitutional applications, rather than to invalidate the statute facially as to *all* of its applications. *Id.* at 968. Such a presumption in favor of narrower injunctive relief makes eminent sense, because it ensures that a court will not "frustrate the expressed will of Congress or that of the state legislatures" by enjoining the enforcement of a law even in situations in which such enforcement is, or would be, constitutional. *Barrows* v. *Jackson*, 346 U.S. 249, 256-257 (1953).

2. Respondents contend that, to the extent that the Act is invalid because it lacks a health exception, the presumption against facial invalidation has been overcome because it is clear that Congress purposefully adopted a statute without a health exception. Carhart Br. 47-49; Planned Parenthood Br. 47-48. That contention too, however, would invert the *Ayotte* presumption. Anytime a constitutional defect results from the omission of a necessary exception, that omission will always be, at least to some extent, intentional. If that were enough to invalidate a law, the Court in *Ayotte* would have affirmed the facial invalidation of the statute at issue. It did not, because, under *Ayotte*, the relevant question is whether Congress would have preferred *no statute at all* to a statute with a (judicially crafted) health exception. See 126 S. Ct. at 968. Respondents' only answer is the non sequitur that Congress deliberately delayed passage of the Act for political reasons. See Planned Parenthood Br. 48. But even assuming that were true, it would say nothing about the substantive

scope of the Act. The better view, based both on Congress's statutory findings and the statements of various members, is that the proponents of the Act would have preferred to ban partial-birth abortion in at least some circumstances, even if they could not have banned it altogether. See 05-1382 Pet. Br. 43. That would be particularly true to the extent that a court could craft a narrow health exception applicable only to particular verifiable medical conditions, which would pose few, if any, of the concerns evident in the debate over a blanket health exception.

3. Respondents and their amici contend that narrower injunctive relief would nevertheless be inappropriate because (1) it would be difficult to predict what sort of health exception Congress would have wanted and (2) it would require the Court to anticipate all of the specific circumstances in which the Act could not constitutionally be applied. Carhart Br. 49; NARAL Br. 10-12. As to the first concern, however, given the abundant evidence that Congress would have preferred to prohibit partial-birth abortion to the fullest extent possible, it is safe to assume that Congress would have opted for the narrowest exception that meets constitutional requirements. And as to the second concern, it is the *plaintiffs'* obligation in a facial challenge to identify the specific circumstances in which the statute being challenged cannot constitutionally be applied (and in which the statute's application should therefore be enjoined). Any difficulty in identifying those circumstances here is attributable to the deficiencies in respondents' evidence. And to the extent that this Court were to conclude that any such circumstances existed, it could readily enjoin the Act's application in those circumstances—without foreclosing later plaintiffs from showing that the Act cannot constitutionally be applied in *other* circumstances (and that the Act thus should be enjoined in those circumstances as well).

4. Finally, respondents argue that any overbreadth or vagueness in the Act cannot be cured by a narrower injunction. Carhart Br. 49-50; Planned Parenthood Br. 49-50. As respondents acknowledge, however, insofar as their argument is that it would be impossible to craft an injunction that would clarify that the Act reaches only standard D&E abortions, that is just another way of saying that Congress cannot devise any statute that would permissibly prohibit the inhumane, and, in Congress's informed judgment, medically unnecessary, practice of partial-birth abortion. See, *e.g.*, *id.* at 50. As explained above, that position is at odds with this Court's prior decisions and should be rejected here. The promise of *Stenberg* was that the D&X procedure could permissibly be regulated. The Act as written is an example of such a permissible regulation, and the Court should resist respondents' invitation to revoke that promise through a misguided application of *Ayotte*.

CONCLUSION

For the foregoing reasons and those stated in petitioner's opening briefs, the judgments of the courts of appeals should be reversed.

Respectfully submitted.

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Solicitor General

OCTOBER 2006

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No. 05-1382

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IN THE

Supreme Court of the United States

ALBERTO R. GONZALES, ATTORNEY GENERAL,

Petitioner,

—v.—

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., *et al.*,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

SUPPLEMENTAL BRIEF OF THE PLANNED PARENTHOOD RESPONDENTS

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Act:

"Partial-Birth Abortion Ban Act of 2003," Pub. L. No. 108-105, 117 Stat. 1201 1

Pursuant to Rule 15.8 of this Court, Respondents Planned Parenthood Federation of America, Inc. and Planned Parenthood Golden Gate ("Planned Parenthood") file this supplemental brief to bring to the Court's attention matter from the Brief for the Petitioner, *Gonzales v. Carhart*, No. 05-380 (*cert. granted* U.S. Feb. 21, 2006) ("*Carhart*") (May 22, 2006) ("*Carhart* Merits Brief"), which is relevant to the disposition of the instant Petition for a Writ of Certiorari (May 1, 2006) ("Petition").[1] In two respects, the *Carhart* Merits Brief reveals fallacies in the continued insistence of Petitioner Alberto R. Gonzales ("Government") that granting the Petition here is neither necessary, nor would assist the Court in resolving all of the issues raised in these challenges to the constitutionality of the "Partial-Birth Abortion Ban Act of 2003," Pub. L. No. 108-105, 117 Stat. 1201 ("Act").

First, in the *Carhart* Merits Brief, the Government acknowledges that all of the legal questions presented in the challenges to the Act may not be capable of resolution in *Carhart*. In urging the Court to hold this case pending its decision in *Carhart*, the Government argued that "the Court could exercise its discretion to reach the remedial question in *Carhart* . . . ." Petition at 7. Now, in the *Carhart* Merits Brief, it takes the opposite tack. It states that if the Court finds the Act unconstitutional in any respect, it should remand the case to the Eighth Circuit for consideration of the remedy issue. *See Carhart* Merits Brief at 12 ("Because that inquiry necessarily entails a statute-specific consideration of legislative intent, in light of an identified constitutional difficulty with the statute, it would be appropriate for the Court to leave that issue for remand . . . ."); *see also id.* at 49-50.

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[1] Respondents in *Carhart* have received an extension of time to August 10, 2006, to file their merits brief.

This very suggestion belies the assertion that *Carhart* can, and will, dispose of all the issues presented here. It also undermines the Government's claim that the Court need not grant review here because this case could be "held pending the Court's decision in *Carhart*, and then disposed of as appropriate in light of that decision." Petition at 8. If *Carhart* is remanded on the remedy issue, the Court will either need to await completion of that step before taking action on this Petition or grant the Petition to decide the remedy issue, which the Ninth Circuit already decided.

By granting the Petition, the Court could avoid these additional steps. The Ninth Circuit here—unlike the Eighth Circuit in *Carhart*—fully analyzed and decided the remedy question in light of this Court's decision in *Ayotte v. Planned Parenthood of Northern New England*, __ U.S. __, 126 S. Ct. 961 (2006). It is ripe for review.

Second, in the *Carhart* Merits Brief the Government fully briefs the two legal claims—undue burden (which the Government now calls "overbreadth") and vagueness—that were not decided by the Court of Appeals in *Carhart*, or, in the case of the vagueness claim, even preserved for review.[2] *See Carhart* Merits Brief, Argument, Point II. While this Court can read the lower court rulings in this case with respect to those claims, unless certiorari is granted here, this Court will not have the benefit of the full record in this case on those claims, or the briefing of the attorneys that developed that record and litigated the claims.

Because this case is the only one where the Court of Appeals considered and decided the proper remedy in light of this Court's ruling in *Ayotte*, as well as the

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[2] *See* Brief of the Planned Parenthood Respondents in Response to Petition for a Writ of Certiorari (May 12, 2006), at 8.

undue burden and vagueness claims, the Court should grant the Petition and consider this case together with *Carhart*.

Respectfully submitted,

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In The
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ALBERTO R. GONZALES,
Attorney General,

Petitioner,

v.

PLANNED PARENTHOOD FEDERATION
OF AMERICA, INC., *et al.*,

Respondents.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Ninth Circuit

BRIEF OF *AMICI CURIAE* AMERICAN ASSOCIATION OF PRO LIFE OBSTETRICIANS AND GYNECOLOGISTS (AAPLOG), SENATOR TOM COBURN, M.D., CONGRESSMAN MICHAEL BURGESS, M.D., CONGRESSMAN PHIL GINGREY, M.D., CONGRESSMAN DAVE WELDON, M.D., C. EVERETT KOOP, M.D., ScD., EDMUND D. PELLEGRINO, M.D., IN SUPPORT OF PETITIONER

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INTEREST OF *AMICI*[1]

Amicus American Association of Pro Life Obstetricians and Gynecologists (AAPLOG) is a non-profit medical organization currently consisting of over 2,000 obstetrician and gynecologist members and associates. The American College of Obstetricians and Gynecologists (ACOG) recognizes AAPLOG as one of the largest special interest groups within ACOG.[2] AAPLOG affirms that the physician has two patients and is caregiver to both mother and unborn child.

Amici Senator Tom Coburn, M.D., Congressman Michael Burgess, M.D., Congressman Phil Gingrey, M.D., and Congressman Dave Weldon, M.D., are physicians and members of Congress who voted for or support the Partial-Birth Abortion Ban Act of 2003.[3]

Amicus C. Everett Koop, M.D., ScD., the former Surgeon General of the United States (1981-1989), is Senior Scholar of the C. Everett Koop Institute and the Elizabeth DeCamp McInerny Professor of Surgery at Dartmouth Medical School. *Amicus* Edmund D. Pellegrino, M.D., is Professor Emeritus of Medicine and Medical Ethics and Adjunct Professor of Philosophy at Georgetown

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[1] This brief is filed with the written consent of the parties. Letters of consent have been filed with the Clerk of this Court. No counsel for a party authored this brief in whole or in part. No entities other than the *Amici* or their counsel have made a monetary contribution to the preparation or submission of this Brief.

[2] Elizabeth Shadigian, M.D., the current President of AAPLOG, Watson Bowes, M.D., Curtis Cook, M.D., and Leroy Sprang, M.D., are or have been members of AAPLOG and testified for the Petitioner in this case.

[3] Pub. L. No. 108-105, 117 Stat. 1201, 18 U.S.C. § 1531 (2006).

University. He has served as Director of the Center for Clinical Bioethics at Georgetown University, head of the Kennedy Institute of Ethics, and Director of the Center for the Advanced Study of Ethics at Georgetown.

SUMMARY OF ARGUMENT

This brief critically examines the medical testimony presented to the Northern District of California in *Planned Parenthood v. Ashcroft*, 320 F.Supp.2d 957 (N.D. Cal. 2004), and referenced by the Ninth Circuit in *Planned Parenthood v. Gonzales*, 435 F.3d 1163 (9th Cir. 2006). As demonstrated below, the evidence presented to the district court revealed that D&X is not the "safest medical option" and that D&X is never "medically necessary"[4] for maternal medical conditions or fetal anomalies. Hence, there is no reliable evidence that a prohibition on D&X will increase medical risk to any woman. Accordingly, the Partial-Birth Abortion Ban Act's prohibition of D&X creates no "substantial obstacle" and thus no undue burden under *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).[5]

[4] *See infra* n.42 for a discussion of the phrase "medically necessary."

[5] The record in these cases demonstrates that D&X has been adopted because of the intuition of certain practitioners, without any support from evidence-based medicine. The judgment that medical procedures supported by evidence-based medicine are superior to innovations unsupported by empirical evidence is one traditionally left to the people through the legislative process.

ARGUMENT

As in both the Second and Eighth Circuits,[6] there was strong medical testimony in the Ninth Circuit supporting the Partial-Birth Abortion Ban Act of 2003. Yet despite the strong evidence indicating that D&X[7] is never "medically necessary," the Ninth Circuit Court of Appeals erroneously concluded the following in an opinion written by Judge Reinhardt:

> [A]s the district court found, [D&X] is *in fact the safest medical option* for some women in some circumstances. For example, *women with specific health conditions* and women who are carrying *fetuses with certain abnormalities* benefit particularly from the availability of the [D&X] procedure.

Planned Parenthood v. Gonzales, 435 F.3d at 1168 (emphasis added). In making this conclusion, the Ninth Circuit completely ignored the following evidence, which demonstrates that D&X is not the "safest medical option" and that it is not "medically necessary" for any woman, and

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[6] *See generally* American Association of Pro Life Obstetricians and Gynecologists (AAPLOG), et al., Brief of *Amici Curiae* in Support of Petitioner, *Gonzales v. Carhart*, No. 05-380 (2006) (examining the evidence presented in the Second and Eighth Circuits); *Nat'l Abortion Fed'n v. Gonzales*, 437 F.3d 278 (2nd Cir. 2006); *Carhart v. Gonzales*, 413 F.3d 791 (8th Cir. 2005); *Nat'l Abortion Fed'n v. Ashcroft*, 330 F.Supp.2d 436 (S.D.N.Y. 2004); *Carhart v. Ashcroft*, 331 F.Supp.2d 805 (D. Neb. 2004).

[7] For ease of reference *Amici* refer to partial-birth abortion as D&X, as used by this Court in *Stenberg v. Carhart*, 530 U.S. 914 (2000). D&E refers solely to the dismemberment method.

particularly not for women with certain medical conditions or carrying fetuses with certain anomalies.[8]

I. THE EVIDENCE PRESENTED IN THE LOWER COURT REVEALED THAT D&X IS NOT "THE SAFEST MEDICAL OPTION"

The Ninth Circuit's conclusion that D&X is "*in fact* the safest medical option" is an even stronger conclusion than that of the American College of Obstetricians and Gynecologists (ACOG). *Id.* at 1168. Even in ACOG's problematic[9] *Statement of Policy* on D&X, the organization merely states that D&X "*may be* the best or most appropriate procedure in a particular circumstance."[10] Yet the Circuit made its conclusion in spite of the fact that no empirical data supports its determination. In addition, the Circuit erroneously disregarded reliable evidence concerning the risks of D&X and the fact that adequate medical alternatives exist.

A. No empirical data supports the Ninth Circuit's conclusion that D&X is safer than any other abortion method.

At the time they testified, Respondents' witnesses admitted that there were no published, randomized, peer-reviewed studies, prospective or retrospective, analyzing

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[8] The transcript from the district court in San Francisco is referenced as SF TR [page].

[9] *See* AAPLOG Brief, *supra*, at 16 (examining various problems with ACOG's *Statement*).

[10] American College of Obstetricians and Gynecologists, *ACOG Statement of Policy: As Issued by the ACOG Executive Board* 1061 (Reaffirmed 2004) (emphasis added).

or comparing the safety of D&X to other methods of abortion, including D&E. SF TR 88-89, 101-02, 252, 438, 443, 593-94, 611-13 (Paul, Sheehan, Doe, Broekhuizen). In the absence of such studies, the Circuit could not have made its conclusion that D&X is safer than any other abortion method.[11] Indeed, as Dr. Elizabeth Shadigian testified, because D&X had never been studied in a systematic way, there was *no sound basis* to say it is safer than other methods.[12] *Id.* at 1221, 1232 (Shadigian).

While the district court did hear testimony about a forthcoming peer-reviewed article by Dr. Stephen Chasen comparing D&E and D&X,[13] that study's results do not support the Circuit's conclusion, and the study was severely flawed. As Dr. Chasen himself testified, there "was no significant difference in the complication rate between those women undergoing [D&X] compared to those women undergoing D&E with disarticulation." *Id.* at 1745 (Chasen). From the data, Dr. Chasen concluded that both D&E

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[11] Witnesses from both parties repeatedly testified that randomized studies on D&X are feasible and reliable safety data could be obtained. *See* SF TR 778-79, 922-31, 939-40, 961, 1239-41, 1457 (Creinin, Bowes, Shadigian, Cook).

[12] Dr. Shadigian did a systematic review of all medical literature published nationally and internationally on D&X, and she found that D&X is completely unstudied. *Id.* at 1221, 1229-30, 1244-45, 1297-98 (Shadigian). *See also id.* at 905-06, 987 (Bowes, testifying that there are no published, peer-reviewed prospective or retrospective studies or other valid scientific evidence comparing the safety of D&X and D&E); *id.* at 1093-94, 1125 (Sprang, testifying that he is not aware of any published data regarding the safety or risks of D&X or randomized trials comparing D&E and induction using misopristol).

[13] The study compared 263 D&E procedures with 120 D&X procedures. ST Chasen et al., *Dilation and evacuation at > or = 20 weeks: Comparison of operative techniques*, 190 AM. J. OB. GYN. 1180 (2004).

and D&X are safe procedures; he did not conclude that one method is safer than the other. *Id.* at 1751-52 (Chasen); *id.* at 808, 855-56 (Westhoff, relating that the complication rates in the Chasen study were the same for both D&E and D&X); *id.* at 911 (Bowes, explaining that the complication rates for both D&E and D&X were similar). There were simply no statistically significant differences between the two procedures. *Id.* at 1807 (Chasen).[14]

For example, there was no difference in the median blood loss between the two groups. *Id.* at 855-56, 862-63, 915, 1102-03, 1749, 1807 (Westhoff, Bowes, Sprang, Chasen).[15] There was also no difference in the median operative times. *Id.* at 855, 862-63, 913, 1749, 1807 (Westhoff, Bowes, Chasen).[16] As far as lacerations were concerned, there were 4 genital tract lacerations in each group, and those lacerations comprised 3.3 percent of the D&X procedures, but only 1.5 percent of the D&E procedures. *Id.* at 1103-04 (Sprang). While Dr. Chasen claims that the study revealed no difference in the obstetric outcomes of subsequent pregnancies between the two groups, witnesses from both parties claimed that the study revealed that D&X produced a higher rate of subsequent preterm births than did D&E. *Id.* at 863, 1106-07, 1139-40, 1749-50 (Westhoff, Sprang, Chasen).[17]

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[14] Out of 383 total patients, only 19 had complications resulting from either D&X or D&E procedures. SF TR 1807 (Chasen).

[15] Dr. Chasen admitted that the blood loss between the groups was identical. *Id.* at 1807 (Chasen).

[16] Dr. Chasen admitted that the median operating times were identical. *Id.* at 1749 (Chasen).

[17] A follow-up study by Chasen et al., examining obstetric outcomes after D&E or D&X at greater than or equal to 20 weeks gestation, was

(Continued on following page)

The only three serious complications that occurred took place in the D&E group, but Dr. Chasen admitted that those complications could not have been avoided with D&X. *Id.* at 1808-09 (Chasen). Indeed, Dr. Chasen "readily acknowledge[d]" that, because he performs D&X when possible, the fact that a D&E was performed in those situations indicates that it was not even possible to perform D&X. *Id.* When the one and only study comparing D&X and D&E reveals that, *at the very least*, there is no statistical difference in the safety of D&X and D&E, the Ninth Circuit erred in concluding that D&X is safer than other abortion methods.

Moreover, Dr. Chasen's study was so severely flawed that it is unreliable. First, there was an inadequate number of subjects in the study. In fact, there were so few patients that no conclusions could be reached with any statistical validity.[18] Dr. Chasen admitted that because the number of complications between the D&X and D&E groups was virtually identical, the study did not have sufficient power. *Id.* at 1812 (Chasen); *see also id.* at 1105 (Sprang, stating that a study would require thousands of

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published in 2005, after the lower court's record was closed. *See* ST Chasen et al., *Obstetric outcomes after surgical abortion at > or = 20 weeks' gestation*, 193 AM. J. OB. GYN. 1161 (2005). The study used the previous dataset but somehow found twice as many prenatal patients. No valid safety or preterm birth conclusions can be drawn from this study, because the D&X data were excluded when D&X was performed in the presence of premature preterm ruptured membranes and/or advanced cervical dilation.

[18] Dr. Sprang testified that the study acknowledged its lack of power and that most of the information was not statistically significant, which was "unusual for a study." SF TR 1101-02 (Sprang). Dr. Bowes also testified to the insufficient number of patients in the study. *Id.* at 916, 969 (Bowes).

patients to determine any statistical differences). Additionally, the number of patients in each group was drastically different: almost a two to one ratio of D&E patients to D&X patients. *Id.* at 857 (Westhoff).

Furthermore, there was a substantial difference between the gestational ages between the two groups. *Id.* at 916-17 (Bowes). The median gestational age in the D&E group was 21 weeks, while the median gestational age in the D&X group was 23 weeks. Respondents' witness Dr. Westhoff termed this a "clinically important difference." *Id.* at 808-09 (Westhoff).

Perhaps the most glaring flaw in Dr. Chasen's study was the inadequate follow-up on patients. Because Dr. Chasen did not follow up with patients who returned to other obstetricians, he was not able to assess the subsequent outcomes for 321 of the 383 patients in the study. *Id.* at 1812 (Chasen).[19]

Finally, the Chasen study was not a randomized, prospective study, but was a retrospective review. *See id.* at 851-52 (Westhoff, stating that a randomized study is preferred over a retrospective study). This lack of randomization reduces the reliability of its results. *Id.*[20] Dr. Chasen admitted that because of the study's retrospective

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[19] *See also id.* at 810 (Westhoff); *id.* at 919 (Bowes, stating that the study admitted that not all patients came back to their facility for care and that they only used their own medical records).

[20] In a randomized study, patients are assigned a form of treatment at random. When a study is not randomized, each patient receives treatment based upon the physician's judgment. This leads to selection bias. *See, e.g., id.* at 851 (Westhoff). *See also id.* at 920 (Bowes, stating that the study cannot be reproduced); *id.* at 1101 (Sprang, citing concerns regarding the inclusion criteria).

nature, it does not support a statement that one technique is safer than or superior to another. *Id.* at 1810 (Chasen).[21]

Because there are no studies supporting their claims, the Respondents are left with intuitive, anecdotal "evidence."[22] For example, Respondents claim that D&X is safer because it involves fewer instrument passes. Yet Respondents' witnesses admitted that such claims are unsupported in medical literature and based entirely on intuition.[23] Not only is intuition unreliable, but so are Respondents claims that D&X requires more passes than D&E. One of Respondents' witnesses admitted that the number of passes used is not indicated on medical charts. *Id.* at 762-65 (Creinin). Others admitted that the use of ultrasound technology reduces the number of passes and the risk of injury from instrument passes, and one testified that with ultrasound guidance, her personal experience in injuring a patient with an instrument is less than

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[21] *See also id.* at 252-53 (Sheehan, stating it is difficult to do a retrospective study because statistics are not kept adequately, and that prospective studies are more authoritative).

[22] In the past, physicians have claimed that other procedures are safe and effective based upon their intuition alone, only to be proven wrong at a later date. For example, physicians once believed that electric fetal heart rate monitoring and episiotomies were safe based upon intuition. Studies later revealed physicians' intuition dangerously wrong. *Id.* at 103-05, 109, 439-40, 897, 972-73 (Paul, Doe, Bowes).

[23] *See id.* at 438 (Doe, stating that there have been no peer-reviewed studies evaluating whether multiple instrument passes pose greater risks and admitting that it is an intuitive assessment); *id.* at 593-94 (Broekhuizen, stating that he knows of no peer-reviewed studies, randomized clinical trials, or retrospective trials evaluating whether D&X reduces the risk of injury because of fewer instrument passes and admitting that the belief is based on intuition); *id.* at 682 (Creinin, stating he "feels" D&X is safer with fewer passes).

0.1 percent. *Id.* at 236, 577 (Sheehan, Broekhuizen).[24] The fact of the matter is that regardless of whether a physician uses D&E or D&X, there will always be multiple instrument passes.[25] *Id.* at 763, 777 (Creinin). An alleged number of passes is simply not a sound basis to conclude that D&X is safer than any other abortion method. *Id.* at 1330-31 (Shadigian).

Another claim based on intuition is that D&X is safer because there are fewer bony fragments involved, but there are no published studies specifically analyzing injury to patients from fetal fragments. *Id.* at 224 (Sheehan). And, once again, the use of ultrasound reduces the risk of leaving fetal parts. *Id.* at 236 (Sheehan). Respondents' witness Dr. Broekhuizen testified that a physician should be able to avoid leaving fetal parts by doing a careful procedure and inspection. *Id.* at 573-74 (Broekhuizen). In fact, one of Respondents' witnesses conceded that it is sometimes the safest procedure to remove the fetus in pieces in order to minimize the cervical opening. *Id.* at 740 (Creinin). Additional methods of ensuring the removal of all fetal parts include reconstructing the fetus outside of the mother, using a curette, and feeling inside the uterus for any remaining parts. *Id.* at 1063 (Sprang).[26] As such, Respondents' claim of retained fetal parts or

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[24] *See also id.* at 1127-28 (Sprang, testifying that when ultrasound is used, focusing on the number of passes is too simplistic and that using instruments is safe when a physician can see what he is doing).

[25] Respondents' witness Dr. Westhoff claimed that she can sometimes remove fetal parts with her fingers. *Id.* at 815 (Westhoff). This claim further demonstrates that D&E does not necessarily require more instrument passes than D&X.

[26] "By feel, by ultrasound, and then reconstructing you can know that you have all the material." *Id.* at 1063 (Sprang).

boney fragments is not a sound basis to conclude that D&X is safer than other abortion methods. *Id.* at 1330-31 (Shadigian).[27]

The Ninth Circuit's reliance on Respondents' intuition arguments is unsound. As Dr. Paul, one of Respondents' witnesses, testified, intuition is not a valid research method in the field of epidemiology. *Id.* at 96 (Paul).[28] Another of Respondents' witnesses, Dr. Westhoff, stated that intuition is not a valid analytical method. *Id.* at 846 (Westhoff). Respondents' witness Dr. Drey stated that the "gold standard" for studies is a blind, randomized trial. *Id.* at 347 (Drey). Neither Dr. Chasen's study nor the Respondents' intuitive arguments fulfill this gold standard. In the absence of valid epidemiological studies, the Respondents' arguments and the Circuit's conclusion are merely anecdotal and, as such, unreliable. *Id.* at 1298-99 (Shadigian).[29]

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[27] Respondents' other intuitive claims are that D&X involves a shorter procedure time and less blood loss, but even the flawed Chasen study reveals that these claims are fallacious. Furthermore, blood loss is never measured by physicians performing abortions, and thus any claims that D&X involves less blood loss cannot be substantiated. *Id.* at 237-38 (Sheehan). In fact, Dr. Sheehan testified that a comparison of blood loss cannot be performed. *Id.* at 238 (Sheehan). Respondents' claims in this regard are just "assertions" and are "not based on any kind of study." *Id.* at 1331 (Shadigian).

[28] Dr. Paul also testified that a randomized control trial is the best form of study, and peer review ensures that the research methodology used is appropriate. *Id.* at 97-98 (Paul).

[29] Dr. Bowes ranked different studies according to reliability, and case reports, such as those of Doctors Haskell and McMahon, fell on the "lowest rung of the ladder." *Id.* at 891 (Bowes). The "ultimate in evidence-based medicine" is the randomized control trial, which eliminates much of the bias involved in retrospective studies. *Id.* at 892-93 (Bowes). No randomized control trials have been performed examining the effects of D&X or comparing it to other methods of

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B. The Ninth Circuit disregarded reliable testimony about the short-term and long-term risks of D&X.

While giving undue weight to the anecdotal evidence and opinions of the Respondents' witnesses, the Court disregarded reliable testimony about the inherent risks and complications of D&X. Yet D&X presents serious safety risks to the mother. *Id.* at 1079 (Sprang); *id.* at 1497 (Cook, stating his immediate concerns are bleeding, infection, uterine perforation, and triple lacerations).

One substantial short term risk is perforation of the uterus. Respondents' witness Dr. Broekhuizen testified that when the fetus's head is lodged in the cervix, puncturing it with a sharp instrument could accidentally perforate the uterus, causing significant bleeding. *Id.* at 631-33 (Broekhuizen). *See also id.* at 1079, 1090-91 (Sprang, testifying that there is a risk of trauma from using a sharp instrument, as D&X is a fairly blind procedure and the scissors can go to the right or left of the fetus's skull). There is potential to puncture the uterine artery, because the physician is forcibly pushing scissors through the skull within close proximity to the artery. *Id.* at 1090-91 (Sprang); *id.* at 1412-13 (Cook, testifying that exposing the cervix to the boney skull increases the risk of bleeding and lacerations). In fact, Dr. Sprang testified that piercing the uterine artery could be "easy." *Id.* at 1091 (Sprang).

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abortion. Without such an unbiased study, the Circuit's conclusion that D&X is safer than other methods of abortion is not based on the trial testimony from either side, but is yet another unreliable "intuitive" judgment.

Performing an internal podalic version,[30] or maneuvering the fetus within the mother, can also cause trauma to the patient's uterus and is the most common cause of traumatic uterine rupture. *Id.* at 1079, 1086 (Sprang). Internal podalic version can also cause internal hemorrhage. *Id.* at 1087 (Sprang). In addition, when the placenta is disrupted, some of that material can get into the maternal circulation and cause amniotic fluid embolism in the mother. *Id.* at 1086 (Sprang).

Another short term risk is the harm caused by serial dilation.[31] Respondents' witness Dr. Creinin admitted that D&E is actually safer to perform than D&X because D&X involves more dilators, causing more pain and potential injury to the cervix. *Id.* at 744 (Creinin). In addition to pain, the use of laminaria to dilate the cervix increases the risk of infection and bleeding. *Id.* at 1079 (Sprang). When laminaria are inserted, there is trauma to the woman's tissue, which enhances bacterial growth. *Id.* at 1083-84 (Sprang). Very large numbers[32] of bacteria are present in the vagina, and that bacteria works its way up the laminaria from the vagina to the internal os, next to the amniotic sac. *Id.*; *see also id.* at 1412, 1423, 1450 (Cook, testifying that the excessive cervical manipulation and

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[30] ACOG's definition of D&X includes "instrumental conversion of the fetus to a footling breech." *ACOG Statement of Policy*, *supra*, at 1060.

[31] ACOG's definition of D&X includes "deliberate dilation of the cervix, usually over *a sequence of days*." *Id.* (emphasis added).

[32] Dr. Sprang testified that the actual number of bacteria present is 10 to the ninth – or 10 with nine zeros added. SF TR 1085 (Sprang).

dilation increase the risk for bleeding, laceration, and infection).

Dilation for D&X can take days, and the longer the amount of time the laminaria are inserted, the greater the risk of bringing bacteria from the vagina to the cervix. *Id.* at 1084 (Sprang). Furthermore, the sticks of laminaria can break the amniotic sac, which significantly increases the risk of infection by bringing bacteria directly into the uterine cavity. *Id.* at 1084. Because laminaria may be inserted on day two, if a physician waits until day three to do the procedure, foreign bodies may sit in the cervix for 24 hours. *Id.* at 1085 (Sprang).[33]

In addition to the risk of perforation, dilation, bleeding, and infection, D&X poses significant long term risks. During D&X, the cervix is dilated more than in any other abortion method. *Id.* at 1386, 1413 (Cook). This massive amount of dilation threatens the integrity of the cervix and can lead to cervical incompetence, which in turn can lead to preterm birth.[34] *Id.* at 1413 (Cook). Despite the

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[33] Dilation with laminaria for D&E does not pose the same risks as it does with D&X – D&X uses more laminaria over an extended period of time. *Id.* at 1307 (Shadigian).

[34] Preterm birth occurs when a baby is born before the 37th week of gestation. It is the leading cause of infant morbidity and mortality. *Id.* at 1254-56 (Shadigian). Dr. Cook testified that there is strong data that subsequent preterm birth and low birth weight occur after first trimester abortions, which indicates the risk would be even greater later in gestation. *Id.* at 1487, 1495-96 (Cook); *see also id.* at 1081-82, 1137 (Sprang, testifying that cervical incompetence is more prevalent at and after the midtrimester); *id.* at 1414 (Cook, testifying that an increasing body of evidence demonstrates that women who have first trimester abortions suffer an increased risk of premature deliveries due to cervical incompetence-related issues). The more abortions a woman has, the higher the chance that she will have a preterm birth. *Id.* at 1256 (Shadigian).

flawed follow-up procedures, the Chasen study revealed that the number of preterm births following D&X procedures tripled the number of preterm births following D&E procedures. *Id.* at 1814-15 (Chasen); *id.* at 863 (Westhoff). In fact, Dr. Chasen admitted that D&X is a possible cause of preterm birth. *Id.* at 1815 (Chasen).[35]

C. The Ninth Circuit ignored evidence that well-established alternatives exist.

In erroneously concluding that D&X is the safest method of abortion for some women, the Ninth Circuit ignored evidence that medical induction and D&E have been the subject of many peer-reviewed studies over the past 20 years and are widely considered "safe."[36] Respondents' witnesses testified that either induction or D&E are safe. *Id.* at 103, 194, 430, 580, 718-19, 748-49, 846, 1819 (Paul, Sheehan, Doe, Broekhuizen, Creinin, Westhoff, Chasen). The "prevailing thought" is that there are other, well-established, safer methods than D&X available. *Id.* at 1390 (Cook); *see also id.* at 1227 (Shadigian).[37]

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[35] Respondents' witness Dr. Westhoff testified that the belief that D&X does not lead to cervical incompetence is simply a belief, and a mere belief is not given much weight in epidemiology. *Id.* at 845 (Westhoff). Dr. Creinin testified that cervical incompetence can result from surgical abortion. *Id.* at 751 (Creinin).

[36] While AAPLOG's position is that medical induction and D&E are *safer* than D&X, no abortion is completely "*safe*," as short-term and long-term complications are well documented in the medical literature.

[37] *See also id.* at 1415, 1423 (Cook, stating that the risks of dilation and preterm birth with D&X "go above and beyond other abortion techniques" and that D&X "poses an increased risk for bleeding or infection"). Indeed, with D&X, the cervix is dilated more than in any other method. *Id.* at 1386 (Cook).

No empirical evidence exists that induction or D&E are less safe than D&X. Respondents' witness Dr. Broekhuizen testified that D&E is a safe procedure, and that ultrasound makes D&E safer and easier. *Id.* at 575-78 (Broekhuizen). Dr. Creinin, also testifying for Respondents, admitted that it is sometimes safest to minimize the cervical opening and remove the fetus in pieces with D&E. *Id.* at 740 (Creinin).

Of the available abortion procedures, medical induction is the most physiological, natural process, and it does not necessarily require any instrument passes. *Id.* at 1093, 1127, 1392 (Sprang, Cook). Surgical methods, such as D&X and D&E, are "decidedly nonphysiologic[al] phenomena." *Id.* at 1478 (Cook). In fact, Dr. Cook testified that medical induction is more natural than a shorter D&E process. *Id.* at 1481 (Cook). Not only is induction the least traumatic of the procedures, but it also involves constant monitoring by trained medical professionals in a controlled setting. *Id.* at 1331, 1392, 1400-01, 1476-77 (Shadigian, Cook). Induction is also the best way to treat women with underlying conditions or complicated pregnancies. *Id.* at 1480-81, 1499 (Cook). Dr. Cook testified that it also renders an intact fetus with an intact nervous system for pathological examination. *Id.* at 1358-59, 1392 (Cook).

The district court also heard testimony from both parties that induction is safer than D&E or D&X. Respondents' witness Dr. Broekhuizen testified that induction has less risk of injury from instrumentation and trauma to the uterus than D&E, and Dr. Sprang testified that induction

is safer for the cervix than either D&E or D&X.[38] *Id.* at 579, 1136 (Broekhuizen, Sprang).[39]

In fact, at 20 weeks gestation and later, medical data demonstrates that induction is safer than D&E. *Id.* at 578-79, 1122-23, 1202, 1225, 1229, 1303, 1499-1500, 1516 (Broekhuizen, Sprang, Shadigian, Cook). Thus, even when D&X is included in D&E data and the D&E data is used, induction is safer than D&X after 20 weeks. *Id.* at 1263, 1303 (Shadigian). Even without the use of misopristol during inductions, studies reveal that induction is the safer procedure at 21 weeks gestation and later. *Id.* at 1269-70 (Shadigian). The use of misopristol renders even better safety data. *Id.* at 1226 (Shadigian). There is simply no sound basis to claim that D&X is safer than induction. *Id.* at 1302 (Shadigian).

To the contrary, abundant testimony in the record confirms that D&X is never "medically necessary" because there are safer, readily available, and well-established alternatives.[40]

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[38] Dilation during induction is different than dilation during D&E (or D&X), as dilation during D&E requires the use of dilators, which is not physiological. *Id.* at 1259 (Shadigian). Induction causes the woman's uterus to contract, which slowly dilates the cervix in a physiological manner. *Id.* at 1259-60 (Shadigian).

[39] Dr. Broekhuizen also testified that if an infection were to arise during an induction, the patient could be treated with an antibiotic immediately and given adequate pain relief. *Id.* at 580 (Broekhuizen).

[40] *Id.* at 1453 (Cook, testifying that D&X is not necessary because there are other procedures readily available); *id.* at 1454 (Cook, stating that D&X is not necessary because there are preexisting, well-established options readily available that have been demonstrated to be safe); *id.* at 1509-10 (Cook, testifying that if a woman is unstable and the fetal head is not yet delivered, options include hand manipulation, forceps, or Duhrssen's incision); *id.* at 1779-80 (Chasen, stating that if

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II. THE EVIDENCE PRESENTED IN THE LOWER COURT REVEALED THAT D&X IS NEVER "MEDICALLY NECESSARY" FOR MATERNAL MEDICAL CONDITIONS OR FETAL ANOMALIES

A. The record demonstrates that D&X is never "medically necessary" for maternal medical conditions.

The claim that D&X is "medically necessary" is entirely theoretical.[41] Witnesses from neither side identified or recalled real-life conditions, in their own practice or otherwise, where D&X was necessary for maternal medical conditions.[42] For example, Dr. Shadigian stated that she has never had to use D&X to treat "even sick women with medical conditions," and she has never seen any of

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the calvarium is trapped, there are multiple options). *See also id.* at 1822 (Chasen, affirming that D&X "is never the only available procedure to terminate a second-trimester pregnancy"); *id.* at 1412, 1455 (Cook, stating that "there are safer and readily available alternatives [to D&X] to emptying a uterus . . . this procedure [D&X] doesn't offer anything new to what we have available").

[41] The lower courts erred by applying a vague and subjective standard ("medically necessary to preserve women's health"). The terms "medically necessary" and "health" have become terms of art with broad definitions unique to abortion law. A "medically necessary" abortion is whatever an abortion provider, in his or her subjective judgment, determines it to be. "Health risk," in abortion law, has come to mean the potential for exposure to the chance of a loss of "well-being" under *Doe v. Bolton*, 410 U.S. 179 (1973). *See* AAPLOG Brief, *supra*, at 3-6. Because this standard contradicts *Casey*, this Court should reject it and ask more precisely ***whether there is substantial, reliable evidence that the D&X procedure is necessary to successfully treat any maternal or fetal condition or is significantly safer than existing procedures. Herein, the phrase "medically necessary" refers to such a standard.*** *See id.*

[42] *See, e.g.*, SF TR 1108-09, 1226, 1292, 1390, 1394, 1411, 1415-16, 1419, 1431, 1453, 1524 (Sprang, Shadigian, Cook). The testimony of Respondents' witnesses is void of any examples.

her colleagues use it "to take care of even the sickest women." *Id.* at 1220 (Shadigian). Dr. Sprang asserted that he has "never seen a situation where an intact D&X method was necessary. . . ." *Id.* at 1111 (Sprang).

Respondents' witness Dr. Creinin admitted that the only medical condition he could imagine was "a theoretical example" – and in practice, he himself used hysterotomy for that situation. *Id.* at 686-89, 769-70 (Creinin). Similarly, Dr. Broekhuizen indicated only one situation where D&X might be used, but in his practice he used induction in that situation. *Id.* at 591-97 (Broekhuizen).

In addition, there are no valid medical studies supporting the claim that D&X is ever "medically necessary" for maternal medical conditions. Neither the AMA Task Force nor the ACOG select panel could "find any medical conditions" or "come up with any situations that would require an intact D&X." *Id.* at 1110 (Sprang).

Thus, contrary to the Ninth Circuit's conclusions, D&X is not "medically necessary" for any of the following conditions:

Blood Loss

D&X is not "medically necessary" for women who suffer from bleeding-related disorders. Instead, induction under the controlled and monitored setting of a hospital is preferred because of the double safety net it provides: first, it is the more natural, physiological procedure, and second, when done in a hospital setting, sophisticated monitoring and highly-trained specialists are available to treat the mother. *Id.* at 1473-81 (Cook). This double safety feature makes induction under a hospital setting "the safest way

to deliver patients with underlying medical complications." *Id.* at 1480-81 (Cook).

When a woman is diagnosed with preeclampsia or HELLP syndrome, D&X is never necessary because there are "safer techniques available." *Id.* at 1420 (Cook). A physician must "avoid[] operative procedures, if at all possible." *Id.* at 1392, 1420-21 (Cook).[43] Induction would be the "most appropriate procedure,"[44] as it avoids risk of perforation, uterine trauma, cervical laceration, and potentially uncontrolled bleeding.[45] Safety data demonstrate that in cases of preeclampsia, induction is healthier and faster than D&X or D&E. *Id.* at 1265 (Shadigian). In addition, D&X is not necessary in cases of preeclampsia because, according to Respondents' witness Dr. Chasen, the pregnancy doesn't need to end in minutes or hours, but in a day or two. *Id.* at 1764 (Chasen).

For women with anemia, low platelet counts, or on blood-thinning medication, D&X "poses an increased risk for bleeding or infection because of the amount of dilation in the intrauterine manipulation." *Id.* at 1423 (Cook). Again, the patient should deliver "in as natural and controlled and as monitored a situation as possible," which

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[43] *See also id.* at 1392 (Cook, testifying that physicians should utilize the most natural process and controlled setting as possible).

[44] *Id.* at 1391 (Cook); *see also id.* at 1223, 1265 (Shadigian, stating that she generally uses induction, or if a fetus is viable, cesarean section); *id.* at 1421 (Cook, testifying that induction is safest and most natural).

[45] *Id.* at 1391, 1466 (Cook).

would mean "induction in a hospital" under "close monitoring of her fluid status. . . ." *Id.* at 1400, 1423 (Cook).[46]

In the case of inherent renal conditions, such as glomerulonephritis, and secondary renal conditions, such as diabetes, D&X is never necessary. *Id.* at 1421-22 (Cook). Induction is always preferred so as not to put the mother "at risk of perforation." *Id.* at 1466 (Cook).

D&X is also not "medically necessary" for women with cardiac or pulmonary diseases such as peripartum cardiomyopathy, Eisenmenger's syndrome or left-to-right shunting disorder, marfan syndrome, severe aortic stenosis, dilated aortic route, and pulmonary hypertension. *Id.* at 1424-27 (Cook). Induction under intense monitoring and critical care support in a supervised hospital setting is always the first option and is preferred as the safer, more superior, least invasive, and most natural physiologic process. *Id.* at 1400, 1427-28, 1467-69, 1471 (Cook).

Placenta Previa

D&X is never "medically necessary" for women with placenta previa.[47] Placenta previa is a contraindication of vaginal delivery, by surgery or by induction, and in some circumstances it is "a contraindication to even doing a vaginal exam." *Id.* at 1429-30 (Cook). Vaginal delivery by surgery or induction in this case would place the mother at significant risk of severe bleeding complications. *Id.* at 1429 (Cook). Respondents' witness Dr. Chasen admitted

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[46] *See also id.* at 1423 (Cook, recommending medical induction for women with anemia and low platelets).

[47] Placenta previa is not in itself an indication for termination of pregnancy. *Id.* at 1428 (Cook).

that in the case of placenta previa, "my choice . . . would be hysterotomy." *Id.* at 1768 (Chasen).[48]

Uterine Infection

D&X is never medically necessary for women with uterine infection such as sepsis. *Id.* at 1429 (Cook). Dr. Shadigian and Dr. Cook emphasized that surgery must be avoided when uterine infection develops in order to prevent exposing other areas of the mother's body to infection. *Id.* at 1267, 1430 (Shadigian, Cook). Indeed, surgical termination or any other procedure that would increase the risk for uterine trauma would be contraindicated in the case of uterine infection. *Id.* at 1430 (Cook). Medical induction under careful monitoring, antibiotics, and fluid administration is the procedure utilized because it would limit infection. *Id.* at 1268, 1430 (Shadigian, Cook). Induction may also be more expedient, especially when using misopristol, thereby ensuring that the infection does not continue for longer periods of time. *Id.* at 1268 (Shadigian).

In addition, D&X is never medically necessary for women with chorioamnionitis. In a situation where the mother has chorioamnionitis and is already dilated and presenting with fetal parts, it is the infection itself that causes labor, and the delivery will occur rapidly. *Id.* at 1474-75 (Cook). Under this circumstance, the doctor should do everything to avoid intrauterine manipulations.

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[48] *See also id.* at 1439 (Cook, stating that no one he knows would ever "recommend a vaginal procedure, let alone a surgical vaginal procedure in a patient with placenta previa," as D&X would potentially compromise the mother's health and life); *id.* at 1440-41 (Cook, testifying that D&X is "decidedly inappropriate" for a woman with placenta previa).

Id. at 1474 (Cook). Continuation of labor in this situation is recommended as being "the safest, most natural, least risky procedure." *Id.* at 1474-75 (Cook).[49]

Uterine Scarring

D&X is never "medically necessary" for women with uterine scarring from a prior cesarean section or other uterine surgery. *Id.* at 1436 (Cook). Valid medical study revealed that induction using an E2 type of prostaglandin is safe for women with uterine scarring. *Id.* at 1432 (Cook). There was no data showing an increased risk of maternal morbidity. *Id.* at 1432-34 (Cook). Dr. Cook stated that for women with uterine scars, studies found that physicians should proceed with induction using E2 prostaglandins. *Id.* at 1432 (Cook). The risk of rupturing a uterine scar during an induction is negligible with the correct timing of prostaglandin administration and monitoring. *Id.* at 1435 (Cook). In cases where there has been a prior rupture of a uterine scar, a hysterotomy is the established and recommended choice. *Id.* at 1434-36 (Cook).

Emergency Situations

Medical testimony demonstrated that D&X is never "medically necessary" in emergency situations that require immediate uterine evacuation. Dr. Shadigian testified that D&X is never an appropriate procedure in an emergency situation because dilation requires two days, and some sick women may "be near death" and "don't have two or three days." *Id.* at 1227 (Shadigian). Dr. Sprang asserted that when the fetus must be removed as quickly as

[49] *See also id.* at 1224 (Shadigian, testifying that in cases of chorioamnionitis, induction is most often used).

possible, D&X "would never be the only choice and never be the best choice," and "could not be used" because it takes too long. *Id.* at 1112 (Sprang). Dr. Chasen reiterated Dr. Sprang's conclusion, asserting that in a real emergency situation where the woman "needs to be delivered that minute," he would choose to use a hysterotomy, not D&X. *Id.* at 1768 (Chasen). Furthermore, Dr. Cook testified that in emergency situations involving significant bleeding or infection, D&X is unnecessary and inappropriate because it would "worsen or exacerbate that situation" and "because we have other safer and readily available alternatives at our disposal." *Id.* at 1436-37 (Cook).

Furthermore, Respondents' witnesses testified most emphatically that they do not distinguish between D&E and D&X before beginning a procedure, and that when an abortion procedure ultimately results in the performance of a D&X, it occurs unpredictably.[50] Witnesses testified that they "never know,"[51] "can't predict,"[52] and "have no control over"[53] the amount of dilation that will be achieved, and consequently over whether or not a D&X will be performed. Dr. Paul, testifying for the Respondents, stated that, when the abortion procedure is already underway, she decides to attempt a D&X "[i]f . . . I think I can accomplish it." *Id.* at 70 (Paul). *See also id.* at 205 (Sheehan, testifying that she simply sets out to terminate a pregnancy).

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[50] *Id.* at 44-45, 188-89, 205, 458, 521 (Paul, Sheehan, Doe, Broekhuizen).

[51] *Id.* at 436, 462 (Doe).

[52] *Id.* at 71, 89, 402, 407, 420, 458, 511-12, 522, 681 (Paul, Doe, Broekhuizen, Creinin).

[53] *Id.* at 206 (Sheehan).

Respondents' witnesses also testified that factors unrelated to maternal health determine which procedure they will use. These factors include "the availability of a trained provider" and the "training, experience, and skill" of the physician. *Id.* at 43, 944 (Paul, Bowes). Dr. Broekhuizen emphasized that the most important factor is the choice and request of the patient. *Id.* at 536 (Broekhuizen). None of these factors – availability and skill of the physician, opinion, and the personal request of the patient – are in any way related to "medical necessity."

B. The record demonstrates that D&X is never "medically necessary" for fetal abnormalities.

D&X is never "medically necessary" for women carrying fetuses with abnormalities. Not a single witness could identify a fetal anomaly that required D&X.[54] Dr. Broekhuizen could identify only two fetal anomalies where he believed D&X might be indicated, and in the first case, he actually used induction. *Id.* at 539-40, 599-602 (Broekhuizen). The second situation was a case of hydrocephaly, or excess fluid in the skull. However, "in reality," Dr. Broekhuizen performed D&X not out of "medical necessity," but just "to avoid the cesarean section," and he conceded that a cephalocentesis through the uterine wall could have been performed. *Id.* at 605-06 (Broekhuizen).

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[54] *Id.* at 1229 (Shadigian, testifying that D&X is never necessary to terminate a pregnancy in which there is a fetal anomaly); *id.* at 1230 (Shadigian, stating she has never seen anything unique about fetal anomalies that would require D&X); *id.* at 1441 (Cook, testifying that no fetal anomalies necessitate D&X); *id.* at 1113 (Sprang, stating that he is not aware of any anomalies requiring D&X).

Dr. Shadigian pointed out that D&X is never necessary for fetal anomalies because, as demonstrated by safety data "from many different sources, from many different institutions, both nationally [and] internationally," there are simply better methods. *Id.* at 1229-30 (Shadigian).

In fact, D&X is never "medically necessary" for cases of hydrocephaly, ascites, or hydrops.[55] Established alternatives include a "shunting procedure to bypass the obstruction," "placement of a reservoir into the ventricular system in order to decompress the system," and cephalocentesis. *Id.* at 1447 (Cook). Dr. Chasen also testified that cephalocentesis could be used in cases of hydrocephaly and hydrops. *Id.* at 1761 (Chasen).[56] *See also id.* at 1444 (Sprang, testifying that medical induction is the general procedure for hydrops).

When an intact fetus is desired for a pathological diagnosis, Dr. Chasen admitted that in most cases induction would offer an intact fetus. *Id.* at 1820 (Chasen). Dr. Cook concurred, stating that induction would result in an "intact fetus and an intact central nervous system." *Id.* at 1392 (Cook). In addition, Dr. Chasen and Dr. Doe recommend induction for neurological fetal anomalies because D&X destroys the contents of the brain, rendering the fetal body utterly useless for autopsy purposes. *Id.* at 432-34, 1820-21 (Doe, Chasen).

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[55] In addition, D&X is never "medically necessary" for molar gestation, triploidy, trisomy, cleft lip, ventricular septal defect, and conjoined twins. *Id.* at 1230-31, 1442-45 (Shadigian, Cook).

[56] *See also id.* at 1113-14 (Sprang, testifying that physicians can inject a needle through the uterine or vaginal wall to drain fluid).

Because D&X is not safer than any other method of abortion, and because there are well-established alternatives to D&X, the Act imposes no "substantial obstacle" and no "significant threat to the life or health of a woman." *Casey*, 505 U.S. at 877, 880. The Act "in no real sense deprives women of the ultimate decision." *Id.* at 875. The Act therefore imposes no undue burden in violation of *Casey*.

CONCLUSION

The judgment of the court below should be reversed.

Respectfully submitted,

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IN THE

Supreme Court of the United States

ALBERTO R. GONZALES,
ATTORNEY GENERAL,

Petitioner,

v.

PLANNED PARENTHOOD FEDERATION OF AMERICA, ET AL.,

Respondents.

On Writ of Certiorari to the
United States Court of Appeals for the Ninth Circuit

AMICUS BRIEF OF THE AMERICAN CENTER FOR LAW AND JUSTICE IN SUPPORT OF PETITIONER

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QUESTION PRESENTED

In light of the centrality of maternal "health" arguments in this case, should this Court keep in mind that the assumption that abortion is safer than childbirth is unsupported and apparently incorrect?

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INTEREST OF AMICUS[1]

The American Center for Law and Justice ("ACLJ") is a public interest law firm dedicated, *inter alia*, to the defense of the sanctity of human life. ACLJ attorneys have appeared frequently before this Court as counsel for parties or for amici.

The ACLJ (joined by others) filed an amicus brief in the pending case of *Gonzales v. Carhart*, U.S. No. 05-380, defending the constitutionality of the federal Partial Birth Abortion Ban Act. The present brief is not duplicative of that brief, but rather addresses a different but important subject, namely, the misconception that abortion has been proven to be safer than childbirth.

SUMMARY OF ARGUMENT

The assertion that abortion is safer than childbirth has always been based on a combination of incomplete information and disparate definitions. But during the last ten years, major record-based studies linking deaths to prior pregnancy outcomes have demonstrated that abortion is actually associated with a higher risk of death for women than childbirth. The risk of suicide following abortion, for example, is approximately six times higher. Whereas *Roe v. Wade* made the comparative risks of abortion versus childbirth a critical issue in abortion law, this Court should not ignore this important new evidence.

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[1] The parties in this case have consented to the filing of this brief. Copies of the consent letters are being filed herewith. No counsel for any party authored this brief in whole or in part. No person or entity aside from the ACLJ, its members, or its counsel made a monetary contribution to the preparation or submission of this brief.

ARGUMENT

An understanding about the relative safety of abortion versus childbirth has been an important consideration in this Court's abortion jurisprudence. Most notably, the trimester framework which was established in *Roe v. Wade*, 410 U.S. 113 (1973), and which governed abortion cases until *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), hinged in part on the premise that "until the end of the first trimester mortality in abortion may be less than mortality in normal childbirth." *Roe*, 410 U.S. at 163. *See also id.* at 149 & n.44 (asserting that "[m]ortality rates for women undergoing early abortions, where the procedure is legal, appear to be as low or lower than the rates for normal childbirth") (citing, *inter alia*, abortion mortality figures from U.S. Department of Health, Education, and Welfare (HEW)).

Abortion providers and their advocates, not surprisingly, have regularly repeated the mantra that abortion (at least early abortion) is safer than childbirth. *See, e.g.*, www.prochoice.org/about_abortion/facts/safety_surgical_abortion.html (website of National Abortion Federation) ("Complications from having a first trimester abortion are considerably less frequent and less serious than those associated with birth"); www.guttmacher.org/pubs/fb_induced_abortion.html (website of Alan Guttmacher Institute, the research arm of Planned Parenthood) ("the risk of death associated with childbirth is about 12 times as high as that associated with abortion"); www.aclu.org/reproductiverights/youth/16388res20010401.html (website of ACLU) ("abortion is safer than childbirth"); www.plannedparenthood.org/pp2/portal/files/portal/medicalinfo/abortion/fact-abortion-medical-social-benefits.xml (website of Planned Parenthood Federation of America) (abortion is "eleven times safer than carrying a pregnancy to term"); www.abortionaccess.org/viewpages.php?id=170 (website of Abortion Access Project) (abortion "11 times safer than childbirth"); www.womensmedcenter.com/abortioncare/default.asp (website of Women's Med Center, an abortion

provider) ("Abortion is 5 to 10 times safer than childbirth"); www.safestabortion.com/surgical.html (website of New York OB/GYN, an abortion provider) ("statistically, it is 9 times more dangerous to go through childbirth than to have a surgical abortion").

Respondents Planned Parenthood *et al.* make the same assertion in this case. *See* Decl. of Maureen G. Paul, M.D. at 6, ¶ 18 ("at the gestational ages that most abortions are performed, abortion is many times safer than continuing pregnancy through childbirth") (offered by respondents in support of their motion for TRO and for preliminary injunction).

While the *Roe* Court treated the relative safety of (early) abortion over childbirth as "now-established medical fact," 410 U.S. at 163, this "fact" is no such thing. First of all, the unthinking comparison of maternal mortality and abortion mortality statistics is **not** probative; rather, it is mixing apples and oranges. Secondly, the medical literature strongly, arguably overwhelmingly, suggests that abortion is **poor** health care for women, in particular relative to the alternative of childbirth.

I. ABORTION MORTALITY STATISTICS AND MATERNAL MORTALITY STATISTICS ARE *NOT* COMPARABLE AND THUS DO *NOT* PROVE THAT ABORTION IS SAFER.

Common sense would suggest that the deliberate surgical or chemical interruption of a normal, natural process like gestation would be less healthy than allowing that process to continue. Pregnancy, after all, is not a disease. Nevertheless, national mortality statistics appear, at least at first glance, to show that abortion is safer than childbirth. Thus, for example, the Kaiser Family Foundation, citing statistics from the United States government, quotes an abortion mortality rate of "0.6 per 100,000 abortions," and, "[f]or comparison," a risk of maternal death from childbirth of "6.7 per 100,000 deliveries." *See* Fact Sheet: Abortion in the U.S. (Oct. 2002) (available at

www.kff.org/womenshealth/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14090). A mechanical comparison of these two figures would give the false impression that childbirth is indeed many times more dangerous than abortion.

The problems with such a comparison, however, are many.

A. Inherently Different Measures

First, the measures are intrinsically noncomparable. As the director of the Centers for Disease Control recently explained, the maternal mortality and abortion mortality "measures are conceptually different and are used by CDC for different health purposes." Letter of July 20, 2004 from Julie Louise Gerberding, M.D., M.P.H., Director, Centers for Disease Control, to Walter M. Weber, p. 1. (This letter, as well as the letter that prompted it, are included as addenda to this brief.) In other words, the measures are apples and oranges that cannot be compared one-to-one.

Maternal mortality is determined by dividing maternal deaths by **live births**, not by **pregnancies**. *See, e.g.,* www.cdc.gov/mmwr/preview/mmwrhtml/ss5202a1.htm (Pregnancy-Related Mortality Surveillance -- United States, 1991-1999 (Centers for Disease Control Feb. 21, 2003)) (hereinafter "Pregnancy Mortality") ("Pregnancy-related mortality ratios were calculated by using the number of deaths . . . (numerator) and live-birth data (denominator) . . ."). This will necessarily tend to inflate the mortality rate, as many pregnancies end in miscarriage or stillbirth. For example, a woman who dies from an ectopic pregnancy will count as a maternal death but will not count for purposes of the live birth total.[2] And the far greater number of

[2] Thus, even though many women survive ectopic pregnancies, the supposed maternal mortality rate for all ectopic pregnancies will be infinitely high. There will be **some** maternal deaths in the numerator but **no** live births in the denominator, yielding an infinitely large fraction. Obviously, this is erroneous. Moreover, this error will distort the overall maternal mortality

(continued...)

women who survive an ectopic pregnancy will not be counted at all. Women who suffer miscarriages and die from associated complications will likewise be counted as maternal deaths, but neither they nor the vastly larger number of women who survive miscarriages will count toward the baseline, which requires live birth. The abortion mortality rate, by contrast, counts all abortion procedures, thus maintaining a fuller base (denominator) for rate computation. *See* www.cdc.gov/mmwr/preview/mmwrhtml/ss5212a1.htm (Abortion Surveillance -- United States 2000 (CDC Nov. 28, 2003)) (hereinafter, "Abortion Surveillance 2000") ("National case-fatality rates were calculated as the number of known legal induced abortion-related deaths per 100,000 reported legal induced abortions").

The measures are also conceptually distinct because the overall maternal mortality figures do not account for the stage of gestation. Whereas 55% of maternal deaths occur in the first 42 days (six weeks) of pregnancy, *see* Pregnancy Mortality, *supra* p. 4 (last paragraph of "results" section), the overall maternal mortality rate will misleadingly suggest more than twice the actual, prospective risk of a continued pregnancy, even at that early stage (42 days) of gestation. Obviously, for example, a woman entering her second trimester faces zero risk of a first-trimester death from ectopic pregnancy -- the leading cause of first-trimester maternal deaths, *see supra* note 2 -- yet the undifferentiated maternal mortality rate incorporates those first-trimester deaths. Again, a straight comparison of abortion mortality versus childbirth mortality rates will be erroneous. An abortion cannot eliminate a risk that has already passed. A true comparison would have to assess only the **prospective** risk of continuing the pregnancy, not the risk **throughout** pregnancy.

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[2] (...continued)
rate by adding to the numerator (deaths) while not adding to the baseline denominator (live births). Notably, ectopic pregnancies are the leading cause of deaths in the first trimester. *See, e.g.*, www.cdc.gov/mmwr/preview/mmwrhtml/00035709.htm (Current Trends Ectopic Pregnancy -- United States, 1990-92 (CDC Jan. 27, 1995)). Hence, this is no trivial distortion.

B. Abortion Mortality Undercounting

Second, a fair statistical comparison of the risks of death from abortion versus continued pregnancy is impossible if the underlying data is itself inaccurate or incomplete. The failure to report abortion-related deaths is apparently all too common. David C. Reardon, Thomas W. Strahan, John M. Thorp, Jr. & Martha W. Shuping, *Deaths Associated with Abortion Compared with Childbirth -- A Review of New and Old Data and the Medical and Legal Implications*, 20 J. Contemp. Health Law & Pol'y 279, 286-91 (2004) (hereinafter "Reardon, *Deaths Associated with Abortion*"). This undercounting will in turn yield an underestimate of the abortion mortality rate.

Such underreporting is in some ways perfectly understandable. The woman may have concealed the abortion from her loved ones. The physician or coroner may, to spare the family further grief or stigma (or out of ignorance of the underlying abortion), simply report death as being due to "sepsis" or "hemorrhage" or "embolism" rather than noting an abortion connection. By contrast, there is little incentive to conceal deaths due to childbirth or complications of pregnancy, and such deaths are thus more likely to be counted. And to the extent an **abortion-related** death is reported as a **maternal** death, this will further skew the statistics toward a false view of abortion being relatively safer.

Also contributing to the undercounting of abortion is the unreliability of death certificates or official reports as sources of information regarding associated abortions. *See id.* at 289-90 (noting that official coding standards impede the reporting of abortion deaths). *See also* Mika Gissler, *et al.*, *Methods for identifying pregnancy-related deaths: population-based data from Finland 1987-2000*, 18 Paediatric & Perinatal Epidemiology 448, 451 (2004) (text and Table 2) (94% of abortion-associated deaths were not identified from death certificates or cause-of-death registries alone).

C. Disregard of Non-Immediate Sequelae

Third, abortion mortality rates reflect death ensuing from the procedure itself. *See* Abortion Surveillance 2000, *supra* p. 5 (last paragraph of "Methods" section) ("abortion-related death" defined as death from "direct complication," "indirect complication," or "aggravation of a preexisting condition"). They do **not** reflect longer term adverse consequences. Recent studies indicate, however, that abortion is associated with an increased rate of both short-term and long-term maternal death. *Infra* § II. A fair comparison of abortion with continued childbearing, like a fair comparison of smoking with nonsmoking, would have to take into account not just immediate consequences, but also all other statistically significant increased death risks. Whereas the mortality rates invoked to prove the supposed relative safety of abortion fail to include statistically significant increases in overall mortality after abortion, reliance upon such limited data is dangerously incomplete.

II. PUBLISHED LITERATURE INDICATES THAT, IF ANYTHING, ABORTION IS *MORE* DANGEROUS THAN CONTINUED PREGNANCY.

Published research strongly indicates that abortion, rather than being safer than childbirth, is in fact more dangerous.

In Finland, for example, researchers drew upon national health care data to examine the pregnancy history of **all** women of childbearing age who died for any reason, within one year of childbirth, abortion, or miscarriage, between the years of 1987 and 1994 (a total of nearly 10,000 women). The study found that, adjusting for age, women who had abortions were 3.5 times more likely to die within a year than women who carry to term. Mika Gissler, *et al.*, *Pregnancy-associated deaths in Finland 1987-1994 -- definition problems and benefits of record linkage*, 76 Acta Obstetrica et Gynecologica Scandinavica 651 (1997).

A subsequent study based upon Medicaid records in California likewise found significantly higher mortality rates after abortion. The study linked abortion and childbirth records in 1989 with death certificates for the years 1989-97. This study found that, adjusting for age, women were 62% more likely to die from any cause than women who gave birth. David C. Reardon, *et al.*, *Deaths associated with pregnancy outcome: A record linkage study of low income women*, 95 So. Med. J. 834 (2002).

The Gissler and Reardon studies both showed, *inter alia*, a heightened risk of suicide after abortion.[3] A recent British study found the same thing. Christopher L. Morgan, *et al.*, *Mental health may deteriorate as a direct effect of induced abortion*, 314 British Med. J. 902 (Mar. 22, 1997) (letters section) (found suicide attempts more than four times as frequent after abortion than after childbirth). All three studies are consistent with the many studies documenting adverse emotional consequences after abortion. *See* David C. Reardon, *Abortion Decisions and the Duty to Screen: Clinical, Ethical and Legal Implications of Predictive Risk Factors of Post-Abortion Maladjustment*, 20 J. Contemp. Health L. & Pol'y 33, 39 n.14 (2003) (citing nearly three dozen sources).

A related consequence of abortion is the elevated risk of substance abuse. *See, e.g.*, David C. Reardon & Phillip G. Ney, *Abortion and Subsequent Substance Abuse*, 26 Am. J. Drug & Alcohol Abuse 61 (2000); David C. Reardon, *et al.*, *Substance use associated with unintended pregnancy outcomes in the National Longitudinal Survey of Youth*, 26 Am. J. Drug & Alcohol Abuse 369 (2004); Priscilla K. Coleman, *et al.*, *Substance use among pregnant women in the context of previous reproductive loss and desire for current pregnancy*, 10 British J. Health Psychol. 255 (2005).

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[3] *See also* Mika Gissler, *et al.*, *Suicides after pregnancy in Finland: 1987-94: register linkage study*, 313 British Med. J. 1431 (1996) (suicide rate after induced abortion was six times higher than suicide rate after childbirth).

Of course, abortion can also cause physical harm. This can result directly from the procedure itself (e.g., perforation of the uterus, laceration of the cervix), from the deprivation of the health benefits of continuing pregnancy (e.g., eliminating the protective effect of a full-term pregnancy against breast cancer),[4] or by masking other dangerous symptoms (e.g., a woman with an infection or an ectopic pregnancy may believe her symptoms are merely normal after-effects of abortion, leading her to delay seeking medical help).[5] *See generally* "A List of Major Physical Sequelae Related to Abortion" (Elliot Institute) (available at www.afterabortion.org) (listing sequelae and referencing sources); Reardon, *Deaths Associated with Abortion*, *supra* p. 6, at 311-17 (same).

In sum, there is ample reason to believe that abortion is **detrimental** to maternal health and, if anything, **more likely** to lead to death or other adverse consequences than is continuing the pregnancy.

* * *

This Court should take with a very large grain of salt any assertion that abortion is healthy for women, much less some sort of panacea. There is good reason to believe precisely the contrary.

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[4] *See* Justin D. Heminger, *Big Abortion: What the Antiabortion Movement Can Learn from Big Tobacco*, 54 Cath. U.L. Rev. 1273, 1288-89 & nn.119 & 121 (2005) (citing sources).

[5] *Cf.* Reardon, *Deaths Associated with Abortion*, *supra* p. 6, at 284 & nn.26-27 (CDC does not count as abortion death a death from ectopic pregnancy that ruptures after the woman had an abortion, even though "the deaths are at least partially due to the failure of the abortion provider to verify the site of the pregnancy and the completion of the abortion").

CONCLUSION

This Court should reverse the judgment of the Ninth Circuit.

Respectfully submitted,

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August 3, 2006

ADDENDA

ACLJ
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April 30, 2004

Tommy G. Thompson
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Abortion statistics and maternal health

Dear Secretary Thompson:

In the challenges to the federal partial birth abortion statute, as on many other occasions, the proponents of legalized abortion make the claim that abortion is safer for women than childbirth. There is very good reason to believe that this claim is false. However, a fair scientific examination of this claim is hindered by the way the Centers for Disease Control (CDC) maintains its relative maternal mortality statistics.

I am writing to urge your office to direct a reassessment of the pertinent statistical measures. In short, the HHS should see to it that the American public -- and in particular, women contemplating the choice between abortion and continuing

pregnancy -- have a genuine basis for an honest and meaningful comparison of the relative risks. If, in the alternative, the CDC is unable to provide a basis for a true comparison, it should so state.

The CDC has in the past reported maternal mortality as the "[n]umber of maternal deaths per 100,000 live births." See, e.g., www.cdc.gov/epo/mmwr/preview/mmwrhtml/00054602.htm (Fig. 1, footnote *) (Maternal Mortality -- United States, 1982-1996). Abortion mortality, by contrast, is reported as the number of "[l]egal induced abortion-related deaths per 100,000 reported legal induced abortions." See, e.g., www.cdc.gov/mmwr/preview/mmwrhtml/ss5212a1.htm (Table 19, footnote *) (Abortion Surveillance -- United States, 2000).

Here are some of the concerns with these statistics:

1. Denominator too small for maternal mortality rate

Maternal mortality should reflect deaths per pregnancy, not deaths per live birth. Stillbirths and miscarriages are fairly common occurrences.[1] To count maternal deaths associated with miscarriages, for example, while not counting the pregnancies, improperly inflates the maternal mortality rate.[2]

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[1] See, e.g., www.cdc.gov/nchs/releases/00facts/trends.htm ("6 million-plus pregnancies in 1996 in the U.S. resulted in 3.9 million births, 1.3 million induced abortions and almost a million fetal deaths," i.e., "16 percent [ended] in a miscarriage or stillbirth").

[2] Of course, live births should be counted only once for each labor, regardless of whether the woman bears at one time a single child, twins, triplets, or a greater number.

2. No maternal mortality rate adjustment for gestational stage

The relative risk of aborting versus continuing a pregnancy should reflect the prospective risks only, and not risks associated with stages of pregnancy already passed. For example, ectopic pregnancies cause a significant percentage of maternal deaths, and indeed are the leading cause of deaths in the first trimester. See, e.g., www.cdc.gov/mmwr/preview/mmwrhtml/00035709.htm (Current Trends: Ectopic Pregnancy -- United States, 1990-92). Obviously, a woman entering her second trimester faces zero risk of a first-trimester death from ectopic pregnancy, yet the undifferentiated CDC maternal mortality rate incorporates those first-trimester deaths. An abortion cannot eliminate risks that have already passed; only prospective risks should enter into the comparison.

3. Underreporting of abortion-related deaths

A true statistical comparison of the risks of death from abortion versus continued pregnancy is impossible if the statistics are inaccurate. Thus, the apparently common failure to report abortion-related deaths see www.afterabortion.org/PAR/V8/n2/abortiondeaths.html ("The Cover-Up: Why U.S. Abortion Mortality Statistics Are Meaningless"), underestimates the abortion mortality rate. The same problem would apply to any underreporting of other maternal deaths. (And, of course, abortion-related deaths must be excluded from the maternal mortality rate if any comparison is to be made. Counting abortion deaths as maternal deaths as well -- or instead -- stacks the deck against childbearing and in favor of abortion.)

4. Disregard of non-immediate deaths

Recent studies indicate that abortion is associated with an increased rate of short-term and long-term maternal death. See www.afterabortion.org/physica.html ("A list of Major Physical Sequelae Related to Abortion"). A fair comparison of abortion with continued childbearing, like a fair comparison of smoking with nonsmoking, would take into account all such statistically significant increased death risks.

* * *

Women choose or decline abortions for many different reasons, and the decision for many may represent a complex balance of multiple considerations. It is a grave disservice to withhold from women the information needed for a genuine comparison between abortion mortality and the risk of mortality from continuing the pregnancy. Such information may be decisive for many women. Moreover, abortion businesses, which have profit motives for women to choose abortion, cannot be relied upon to present the full picture. Indeed, such businesses may be using statistics -- despite the flaws described above -- to help sell abortion to trusting lay women. Cf. www.abortion.com/questions.html (claiming that "statistically, childbirth is far more dangerous than abortion").

I strongly urge you to direct the CDC to make all necessary adjustments to its preparation and presentation of statistical data to allow for an honest, unbiased comparison of the relative risks of abortion and continuing pregnancy.

Very truly yours,

/s/
Walter M. Weber
Senior Litigation Counsel

WMW:fd

cc: Timothy Goeglein
Terrell Halaska

DEPARTMENT OF HEALTH
& HUMAN SERVICES

Public Health Service
Centers for Disease Control
and Prevention (CDC)
Atlanta, GA 30333

JUL 20 2004

Mr. Walter M. Weber
Senior Litigation Counsel
American Center for Law & Justice
201 Maryland Avenue, N.E.
Washington, D.C. 20002

Dear Mr. Weber:

We appreciate your interest in the Centers for Disease Control and Prevention's (CDC) efforts to collect and publish maternal mortality statistics (including those related to abortion). CDC makes every effort to identify all such deaths and to present maternal mortality statistics using established scientific methods.

The maternal mortality rate is computed as all maternal deaths per 100,000 live births. In contrast, the measure used for abortions is a case-fatality rate which is computed per 100,000 legal abortions. These measures are conceptually different and are used by CDC for different public health purposes.

CDC calculates the maternal mortality rate per 100,000 live births for the following reasons:

1. To maintain comparability in long term trends for the United States. Estimates of the number of pregnancies (including live births, miscarriages or stillbirths, and induced abortions) in the United States have been published only since the 1970s.
2. The live birth component of the pregnancy estimates is highly reliable. Virtually all births are counted in every year. Estimates of all abortions are based on CDC's abortion surveillance system, which relies on state abortion reporting systems. Estimates of stillbirths, ectopic pregnancies, and miscarriages are based on survey data and are subject to significant sampling error, particularly for smaller population subgroups. Estimates of stillbirths and miscarriages are based on pregnancy history data from the National Survey of Family Growth (NSFG). The NSFG is conducted periodically, every 5 to 7 years. The data are subject to sampling error, particularly for smaller population subgroups. For information on the estimation methodology, see www.cdc.gov/nchs/data/series/sr_21/sr21_056.pdf.
3. To maintain international comparability. Many other countries cannot adequately estimate the number of pregnancies, especially those in which abortion is illegal. Information on miscarriage and stillbirth also varies considerably in completeness. In the interest of international comparability, the World Health Organization has specified that the number of live

births should be used for the denominator of the maternal mortality rate.

Adjusting the maternal mortality rate for gestational stage is not statistically feasible, because this requires data that are not currently completely available. The Pregnancy Mortality Surveillance System (PMSS) relies primarily on death certificates which do not typically provide this information. Gestational age may be available for some maternal deaths in cases where linkage with other records (e.g., birth certificates, fetal death reports) is possible. Information on gestational age for induced abortions is available in about 42 states or jurisdictions.

CDC recognizes that despite efforts to count all maternal deaths (including those abortion-related) in the United States, some remain uncounted. The death itself is reported but accurate information on the cause may not be provided. CDC estimates that maternal deaths in general are underreported by 30 to 15 0 percent (see www.cdc.gov/mmwr/preview/mmwrhtml/ss52 02e1.htm). The nature of the surveillance systems make it difficult to obtain complete data. The PMSS compiles data from 50 states, the District of Columbia, and New York City. Abortion surveillance involves data from 47 states, District of Columbia, and New York City. These systems are voluntary (CDC does not provide remuneration for data) and rely primarily on death certificate data which may or may not provide information that indicates the death was maternal or abortion-related. In the case of deaths associated with induced abortion, CDC also uses searches of computerized print media databases (Lexis-Nexis) to identify additional cases.

At CDC we are very committed to improving data collection systems and providing the most accurate and reliable data on all aspects of maternal and infant health. I hope this information is helpful.

Sincerely,

/s/
Julie Louise Gerberding, M.D., M.P.H.
Director

939C (31)

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SUPREME COURT, U.S.

IN THE

Supreme Court of the United States

ALBERTO R. GONZALES, Attorney General,

Petitioner,

—v.—

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., *et al.*,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR AMERICAN CIVIL LIBERTIES UNION, NEW YORK CIVIL LIBERTIES UNION, AND NATIONAL ABORTION FEDERATION AS *AMICI CURIAE* SUPPORTING RESPONDENTS

ELISABETH RYDEN BENJAMIN
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INTEREST OF *AMICI CURIAE*[1]

The American Civil Liberties Union ("ACLU") is a nationwide, non-profit, non-partisan organization with over 500,000 members dedicated to defending the principles of liberty and equality embodied in the Constitution and the nation's civil rights laws. The ACLU has a long history of vigorously defending the right to privacy – including the right to reproductive freedom – through litigation and advocacy, and has frequently appeared before this Court as both direct counsel and *amicus curiae*. The New York Civil Liberties Union ("NYCLU") is the New York state affiliate of the ACLU.

The National Abortion Federation ("NAF"), a non-profit organization founded in 1977, is the medical professional association of abortion providers in North America. Its members include over 400 non-profit and private clinics, women's health centers, hospitals, and private physicians' offices in 47 states. NAF's members care for over half the women who obtain abortions each year in the United States, and they perform and teach abortion procedures that are banned by the Partial-Birth Abortion Ban Act of 2003, 18 U.S.C. § 1531 (the "Act"). Represented by the ACLU and its co-counsel, including the NYCLU, NAF is the lead plaintiff in *NAF v. Gonzales*, 437 F.3d 278 (2d Cir. 2006), in which the Second Circuit held the Act unconstitutional; ordered supplemental briefing on the question of remedy; but later

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[1] No counsel for a party authored this brief in whole or in part, and no person or entity other than *amici* and their counsel made any monetary contribution toward the preparation or submission of this brief. Pursuant to Rule 37.3, letters indicating the parties' consent to the filing of this *amicus* brief have been submitted to the Clerk of this Court.

stayed that briefing after this Court granted review in one of the other challenges to the Act.

STATEMENT OF THE CASE

Fewer than four years after the Supreme Court struck Nebraska's ban on "partial-birth abortion," *Stenberg v. Carhart*, 530 U.S. 914 (2000), Congress passed the challenged Act. In three separate cases, physicians and medical providers – suing on behalf of themselves and their patients – claimed that the Act suffers from the same constitutional flaws as the Nebraska ban that this Court had struck down: the failure to include an exception to protect women's health, and broad language that sweeps within it the most common second-trimester, pre-viability abortion procedures. All three trial courts and three appellate courts to review the Act agreed that it violates the norms articulated in *Stenberg*. *See Planned Parenthood Fed'n of Am., Inc. v. Gonzales*, 435 F.3d 1163 (9th Cir. 2006), *cert. granted*, 126 S. Ct. 2901 (2006); *Carhart v. Gonzales*, 413 F.3d 791 (8th Cir. 2005), *cert. granted*, 126 S. Ct. 1314 (2006); *NAF v. Gonzales*, 437 F.3d 278. The *NAF* case is stayed pending this Court's review of the other two cases.

SUMMARY OF ARGUMENT

Under review are two of the three decisions in which United States Courts of Appeals have held that the federal "partial-birth abortion" ban flies in the face of this Court's recent ruling in *Stenberg*. Indeed, the Act fails in every respect to meet the requirements this Court set forth in that case. Rather than enact legislation conforming to this Court's clear commands, Congress simply declared that its own "findings" trumped this Court's conclusions. That

declaration is factually inaccurate and legally insufficient. Unsurprisingly, every court to review the Act has held it unconstitutional under *Stenberg* and the longstanding precedent that *Stenberg* applied. The Briefs of Respondents and of other *amici* in the two cases under review explain fully why this Court should affirm. *Amici* submit this brief to address specifically the Government's argument that Respondents cannot show that the Act violates their rights and their patients' rights unless they prove that it is unconstitutional in all – or in at least a large fraction of – its applications.

That argument is contrary to this Court's precedent, under which a plaintiff may prove that a law violates her constitutional rights, without regard to the number or proportion of the law's applications that are unconstitutional. Such "numbers" tests play a role not in determining whether constitutional rights are infringed, but in determining – where rights are infringed – how to remedy the violation. The government's argument that Respondents must meet some numerosity test in order to prove that the Act violates their and their patients' rights must be rejected.

In addition to illustrating that principle -- that a plaintiff need not meet any numerosity threshold in order to prove a violation of rights – the Court's decision in *Ayotte v. Planned Parenthood*, 126 S. Ct. 961 (2006), reveals the basic template for constitutional adjudication: first, even if implicitly, determine that the plaintiff has standing; second, evaluate whether there is a constitutional violation; and third – and only if a constitutional violation has been found – determine the proper remedy, such as facial invalidation or more limited relief. *See also, e.g., United States v. Booker*, 543 U.S. 220 (2005) (separating determination of constitutional violation

and determination of remedy); *United States v. Nat'l Treasury Employees Union*, 513 U.S. 454, 477-80 (1995) (after holding restrictions on government employees' receipt of honoraria unconstitutional under First Amendment, the Court considered the appropriate remedy); *Califano v. Westcott*, 443 U.S. 76, 89-91 (1979) (after holding that government benefit program violated equal protection, the Court assessed whether constitutional violation should be remedied through nullification or extension of the benefits); Adrian Vermeule, *Saving Constructions*, 85 Geo. L.J. 1945, 1956 (1997) (after court holds challenged law unconstitutional, it fashions the appropriate remedy).

The Court does not in every case explicitly delineate each of these steps, or consider them in the order listed above. But as an analytical matter, each inquiry is separate, and the answer to each is determined by distinct criteria.[2] The government's brief, however, routinely injects numbers tests into the analysis of whether a constitutional violation has occurred, even though those tests relate not to that issue, but

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[2] In the context of First Amendment overbreadth cases, where the challenger does not contend that the statute is unconstitutional as applied to her, the only remedy the Court considers is total invalidation. In that situation, it makes sense that the Court addresses the constitutional violation and the remedy in the same breath: to obtain facial invalidation – that is, to obtain the only relief available – the challenger must show that the law punishes a substantial amount of protected free speech. *See, e.g., Virginia v. Hicks*, 539 U.S. 113, 118-19 (2003). But analytically, there are still two separate inquiries. The question of whether the law "punishes ... protected free speech" relates to the constitutional violation. *See, e.g., id.* at 118, 122-23 (determining that the challenged policy would not affect any First Amendment activity). The "substantial amount" (the "numbers" test) relates to whether facial invalidation is appropriate, *i.e.*, relates to remedy. *See, e.g., id.* at 120 (considering "whether the claimed overbreadth . . . is sufficiently 'substantial' to produce facial invalidity").

relate rather to the issue of remedy. Specifically, the government insists that Respondents must meet the "no set of circumstances" test enunciated in *United States v. Salerno*, 481 U.S. 739 (1987), or at least the "large fraction" test developed in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), in order to prove that the Act violates their rights. Pet. Br. at 9, 16 (*PPFA*); Pet Br. at 18-19 (*Carhart*). But in both *Ayotte* and *Casey*, the Court found a constitutional violation, regardless of the fact that the number of women for whom the challenged law was unconstitutional was very small. Indeed, the plaintiffs in those cases did not need to meet any "numbers" test to prove that the provisions in question were constitutionally infirm. Accordingly, as explained in Point I, *infra*, Respondents here need not meet any "numbers" test in order to prove that the Act violates their rights and the rights of their patients.

The government's other assertions are equally meritless. As explained in Point II, *infra*, and as this Court demonstrated in *Ayotte*, the *Salerno* and "large fraction" tests are not the exclusive tests for facial invalidation, and are not thresholds a plaintiff ever needs to meet in order to obtain partial invalidation. Finally, as discussed in Point III, *infra*, the government's assertion that the Ninth Circuit's decision below altered the standard for facial challenges to abortion restrictions is incorrect and inapposite.

ARGUMENT

I. Neither *Casey*'s "Large Fraction" Test Nor *Salerno*'s "No Set of Circumstances" Test Determines Whether the Act Is Unconstitutional.

A court's analysis of whether a statute is constitutionally

infirm is independent of how many – or how few – applications of a challenged law are unconstitutional. Yet the government erroneously suggests that to prove the Act is constitutionally infirm, Respondents must demonstrate, under *Salerno*, "that the statute is invalid in *all* its applications" or that, under *Casey*, the Act would impose medical risks on "at least a 'large fraction' of women covered by the statute." Pet. Br. at 18-19 & n.3 (*Carhart*); *see also* Pet. Br. at 9 (*PPFA*). In other words, the government claims that proving a constitutional violation depends on *how many* applications of a challenged law are invalid. *See* Pet. Br. at 9 (*PPFA*) ("[T]he relevant inquiry" when evaluating the constitutionality of an abortion restriction that lacks a health exception is whether "it places a substantial obstacle in the path of a woman seeking an abortion, in a large fraction of its applications"); *see also* Pet. Br. at 16-17 (*PPFA*); Pet. Br. at 19-20 (*Carhart*). As this Court's precedents demonstrate, the "no set of circumstances" test and *Casey*'s "large fraction" test simply do not bear on the analysis of whether a statute infringes constitutional rights. In general, quantifying unconstitutional applications comes into play only if and when a court has found a constitutional violation, and then proceeds to fashion a remedy.

The Court's recent decision in *Ayotte* demonstrates this principle. The plaintiffs in *Ayotte* claimed that a requirement that physicians notify a minor's parents before performing an abortion was unconstitutional because it failed to include an exception for medical emergencies. The Court held that the law unconstitutionally jeopardized minors' health, even though "pregnant minors, like adult women, need immediate abortions to" protect their health in only "some *very small percentage of cases*." 126 S. Ct. at 967 (emphasis added). The Court thus found a constitutional violation, even though

"[o]nly a few applications of . . . [the] statute would present [such] a . . . problem." *Id.* at 967, 969.

This Court's approach in *Salerno* is consistent with *Ayotte*. While there is debate over the precise meaning, application, and principles embodied in *Salerno*'s "no set of circumstances" test, this Court has never held that it plays a role in determining whether a statute violates constitutional rights. For example, members of this Court and scholars have understood the *Salerno* test as a bar to overbreadth standing. *See, e.g., Sabri v. United States*, 541 U.S. 600, 609 (2004); *City of Chicago v. Morales*, 527 U.S. 41, 55 n.22 (1999) (Opinion of Stevens, J., Souter, J., and Ginsburg, J.); *see also* Michael C. Dorf, *Facial Challenges to State and Federal Statutes*, 46 Stan. L. Rev. 235, 261 (1994) (*Salerno* itself recognized that First Amendment overbreadth doctrine, which relaxes normal standing rules, is an exception to the *Salerno* test). The "no set of circumstances" test is also thought to function as one measure of when total ("facial") invalidation is the appropriate remedy.[3] *See, e.g., Salerno*, 481 U.S. at 745 ("fact that [law] might operate unconstitutionally under some conceivable set of circumstances is insufficient to render it *wholly* invalid") (emphasis added); *see also Morales*, 527 U.S. at 80 n.3 (Scalia, J., dissenting) (*Salerno* rule relates to appropriateness

[3] *Salerno* has, on occasion, been invoked in other contexts as well – though never in the context of determining whether a constitutional violation has occurred. *See, e.g., Rust v. Sullivan*, 500 U.S. 173, 183 (1991) (citing *Salerno* in discussion of constitutional avoidance); *Reno v. Flores*, 507 U.S. 292, 300-01 (1993) (citing *Salerno* in recognizing that plaintiffs' challenge was based only on text of regulation, not the history of its enforcement, since it had been in effect for only one week before district court enjoined it).

of facial invalidation as a remedy, not to standing: a "statute is not *totally* invalid unless it is invalid in all of its applications") (emphasis added); *see also* Matthew D. Adler, *Rights Against Rules: The Moral Structure of American Constitutional Law*, 97 Mich. L. Rev. 1, 154-56 (1998) (characterizing *Salerno*'s "no set of circumstances" test as a mechanism for facial invalidity). The one inquiry that is not affected by the "no set of circumstances" test is whether the challenged statute violates a party's constitutional rights. Indeed, this Court has never held that a party must meet the "no set of circumstances" test – or any other numerosity threshold – for that purpose.

Casey offers yet another example of how this Court has traditionally and consistently determined whether an abortion statute violates the Constitution without regard to how many applications are unconstitutional, including the "large fraction" test enunciated in *Casey* itself.[4] Specifically, the *Casey* Court held that a spousal notice requirement for abortion violated the relevant constitutional standard – the "undue burden" test – despite the fact that the requirement affected only one percent of women obtaining abortions. 505 U.S. at 893-94 (holding that spousal notice provision would "impose a substantial obstacle" to abortion for women in abusive marriages). The numbers were thus irrelevant to whether the requirement violated the Constitution. The "large fraction" test came into play only when the Court turned to the question of remedy, and determined that total invalidation was appropriate because of the provision's broad

[4] Even the government at times recognizes that the "large fraction" test is a test for facial invalidation – i.e., remedy – in abortion cases. *See, e.g.*, Pet. Br. at 18 (*PPFA*); Pet. Br. at 14 (*Carhart*).

impact on battered spouses.[5] *Id.* at 895 (emphasis added); *see also infra* Point II.

In addition, the *Casey* Court demonstrated the independence of constitutionality from remedy (and from "numbers" tests) when it considered the medical emergency exception to the omnibus abortion restriction challenged in that case. The plaintiffs claimed that the law's medical emergency exception was so narrowly drawn that it "foreclose[d] the possibility of an immediate abortion" in certain medical emergencies. 505 U.S. at 880. The Court rejected that interpretation, holding that the exception would apply in all medical emergencies. In adopting this saving construction, however, the Court recognized that the medical emergency exception would otherwise be unconstitutionally narrow, and the Court "would be required to invalidate the restrictive operation of the provision." *Id.* Implicit in that conclusion is that an exception that did not encompass all medical emergencies would violate the Constitution – regardless of the fact that such emergencies occur infrequently.

In this case as well, the analysis of whether the Act violates the Constitution is unaffected by either *Salerno*'s "no set of circumstances" test or *Casey*'s "large fraction" test. Indeed, this principle is illustrated by the two-tiered

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[5] The government incorrectly claims that the "large fraction" test is limited to evaluation of spousal notice requirements for abortion. Pet. Br. at 16 (*PPFA*). The reason that the *Casey* Court applied the "large fraction" remedy test only in relation to the spousal notice requirement was that it upheld the constitutionality of the other challenged provisions, and thus never reached the question of remedy as to those provisions.

approach employed by the Ninth Circuit in its decision below, and by the Second Circuit in *NAF v. Gonzales*, 437 F.3d 278 (holding Act unconstitutional for lack of health exception and deferring ruling on remedy until after additional briefing). This Court should likewise reject the government's attempt to inject a numerosity threshold into the evaluation of whether the Act is constitutionally defective.

II. After a Court Finds a Constitutional Violation, It Must Fashion an Appropriate Remedy.

Upon finding a constitutional violation, a court must determine how to remedy the constitutional defects. The *Ayotte* Court outlined grounds on which a plaintiff can obtain facial invalidation, even where a law is unconstitutional in only a small percentage of its applications. Facial invalidation is the proper course (1) where crafting a narrowing remedy would require making distinctions in a "murky constitutional context," which may invade the legislative domain; (2) where "line-drawing is inherently complex," which may likewise invade the legislative domain; or (3) where severing unconstitutional applications is contrary to legislative intent.[6] *Ayotte*, 126 S. Ct. at 968.

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[6] The government incorrectly suggests that these factors should be relaxed in this case because, "to the extent that federalism concerns inform those limits on judicial competence, such concerns are inapplicable in the context of a federal statute." Pet. Br. at 41 n.10 (*PPFA*). As the *Ayotte* Court demonstrated by its reliance on numerous cases reviewing federal statutes, these "limits on judicial competence," *id.*, also apply when federal legislation is at issue to prevent encroachment on the legislative branch. 126 S. Ct. at 968 (citing, *inter alia*, *Booker*, 543 U.S. at 227 (reviewing federal statute); *Minnesota v. Mille Lacs Band of Chippewa Indians*, 526 U.S. 172, 191 (1999)

Indeed, where a limited injunction is contrary to legislative intent, the law must be struck down on its face – regardless of whether it is constitutional in most of its applications. *Id.* at 968-69. The *Ayotte* Court also counseled against substitution of the "judicial for the legislative department of the government":

> [W]e are wary of legislatures who would rely on our intervention, for it would certainly be dangerous if the legislature could set a net large enough to catch all possible offenders, and leave it to the courts to step inside to announce to whom the statute may be applied.

Id. (internal quotation marks omitted). Contrary to the government's suggestion, therefore, *Ayotte* makes clear that *Salerno*'s "no set of circumstances" test and *Casey*'s "large fraction" test are not the exclusive tests for facial invalidation.[7] Pet. Br. at 13, 18 (*PPFA*); Pet. Br. at 18-19 (*Carhart*).

(reviewing federal executive order); *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 684 (1987) (reviewing federal statute); *The Employers' Liability Cases (Howard v. Illinois Central R.R. Co.)*, 207 U.S. 463, 501 (1908) (same); *Trade-Mark Cases (U.S. v. Steffens)*, 100 U.S. 82 (1879) (same)).

[7] In addition, facial invalidation is appropriate if an unconstitutionally vague statute would reach "'a substantial amount of constitutionally protected conduct.'" *Kolendar v. Lawson*, 461 U.S. 352, 358 n.8 (1983) (quoting *Hoffman Estates v. Flipside*, 455 U.S. 489, 494 (1982)). Facial invalidation of a vague statute is appropriate even "when [a statute] could conceivably have had some valid application." *Kolendar*, 461 U.S. at 358 n.8 (*citing Colautti v. Franklin*, 439 U.S. 379, 394-401 (1979)); *see also Morales*, 527 U.S. at 51, 64 (facially invalidating unconstitutionally vague statute).

It is equally clear from *Ayotte* that a plaintiff who has established the unconstitutionality of the challenged statute is entitled to some relief even if facial invalidation is deemed inappropriate. *See, e.g.*, *Bell v. Hood*, 327 U.S. 678, 684 (1946) ("[W]here federally protected rights have been invaded, it has been the rule from the beginning that courts will be alert to adjust their remedies so as to grant the necessary relief." (citing *Marbury v. Madison*, 1 Cranch 137, 162-63 (1803))). Moreover, a plaintiff's entitlement to some relief from an unconstitutional statute does not depend on meeting either *Salerno*'s "no set of circumstances" test or *Casey*'s large fraction test.

The government ultimately concedes as much. Pet. Br. at 49-50 (*Carhart*) (if the "Court were to identify some aspect in which the Act is invalid, it may be possible to craft narrower injunctive relief"); *see also* Pet. Br. at 40 (*PPFA*) (same). It is a wise concession. After the *Ayotte* Court held that the Constitution required a medical emergency exception in the challenged parental notification law, it remanded for the determination of whether – consistent with legislative intent – a narrow injunction might be crafted. 126 S. Ct. at 969. The Court held that the plaintiffs were entitled to at least such relief, notwithstanding that the law was constitutional in all but "some very small percentage of" applications. *Id.* at 967.

In the face of the Act's constitutional infirmity, and the *Ayotte* Court's holding that a court must craft a remedy after finding a constitutional violation, the government nevertheless proposes – albeit cursorily – that if the Court "conclude[s] that the Act is unconstitutionally vague [or] . . . overbroad," it should simply "issue a narrowing construction

to avoid any constitutional infirmity." Pet. Br. at 39 (*PPFA*); *see also id.* at 36. But such a saving construction is by definition something a court adopts in order to avoid ever making the constitutional determination, and not something a court could adopt once it has made the determination that a law is infirm.[8] Moreover, the government has not proposed any construction that would save the Act,[9] let alone one to which the Act is "reasonably susceptible" or that is consistent with legislative intent. *See, e.g.*, *Clark v. Martinez*, 543 U.S. 371, 385 (2005) ("The canon of constitutional avoidance comes into play only when . . . the statute is found to be

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[8] *See* Vermeule, *Saving Constructions*, 85 Geo. L.J. at 1949, 1959 ("modern avoidance . . . emphatically declines to decide a constitutional question"); *see also Clark*, 543 U.S. at 381 ("The canon [of constitutional avoidance] is not a method of adjudicating constitutional questions by other means."). As *Ayotte* demonstrates, the proper course once a court has found a violation is to fashion a remedy, which may be a limited injunction reaching only unconstitutional applications of the challenged law. Although the difference is subtle, a "narrowing" or "saving" construction is analytically distinct from a limited injunction. Both must be consistent with legislative intent, but they are otherwise subject to different standards: while a saving construction must be an interpretation to which the law is "reasonably susceptible," a limited injunction is appropriate if it satisfies the factors discussed in *Ayotte*. *See supra* at 10-12. Thus, if a court reaches the constitutional question, and finds a violation, it must then fashion a remedy, either partial or facial invalidation, and not – as the government suggests – adopt a saving construction. *See* Vermeule, 85 Geo. L. J. at 1950.

[9] The government's only concrete suggestion involves reading the statute to require a "specific intent to deliver the requisite portion of the fetus for the purpose of performing the ultimate lethal act *at the outset of the procedure*." Pet. Br. at 47 (*Carhart*); *see also* Pet. Br. at 32 (*PPFA*). For the reasons discussed in Respondents' briefs, this construction must be rejected. *See* Br. of Respondents at 42-45 (*Carhart*); Br. of Respondents (*PPFA*).

susceptible of more than one construction; and the canon functions as *a means of choosing between them.*"); *id.* at 382 (a limiting construction under the canon of constitutional avoidance is a "means of giving effect to congressional intent, not of subverting it"). Accordingly, and for the reasons set forth in Respondents' briefs, the Court should affirm the Ninth Circuit's holding that the Act is unconstitutional; then turn to the question of remedy; and affirm that the appropriate remedy in this case is facial invalidation.

III. The Government Incorrectly Claims That the Ninth Circuit Altered the Standard for "As-Applied" and "Facial" Challenges.

The government incorrectly claims that the Ninth Circuit "misstates both the facial-challenge standard and the substantive standard," with "[t]he practical effect . . . that . . . there is no meaningful distinction between as-applied and facial challenges."[10] Pet. Br. at 17 (*PPFA*). The government

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[10] The government's use of the terms "facial" and "as-applied" is confusing because these terms can be used in at least three ways. First, a statute has a "facial defect" if, by its very words, it is at odds with the Constitution. Thus, a statute requiring parental consent for minors' abortions that contains no judicial bypass mechanism has a "facial defect." *See, e.g., Planned Parenthood v. Danforth*, 428 U.S. 52, 72-75 (1976). By contrast, a statute may be unconstitutional "as applied" even if it contains no "facial defect" because the government's manner of enforcement violates the Constitution. A second sense of "facial" and "as-applied" relates to the remedy fashioned by the court: "facial invalidation" means that the government is barred from enforcing a statute in its entirely, while "as-applied invalidation" means that the government is barred from enforcing a statute only in certain applications. *See, e.g., Ayotte*, 126 S. Ct. at 968. A third meaning relates to whether the statute is unconstitutional "as-applied" to the particular plaintiffs bringing the challenge based on certain facts they allege. *See,*

completely misreads the decision of the Ninth Circuit, which in no way altered the standard for facial or as-applied challenges; indeed, the portion of the court's opinion the government cites is focused exclusively on the substantive constitutional standard.[11] *PPFA*, 435 F.3d at 1172

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e.g., *Edenfield v. Fane*, 507 U.S. 761, 780 (1993) (O'Connor, J., dissenting) (one sense of "as-applied challenge" is where the challenger points to some "special feature[]" of his case). The government confuses these meanings when, for example, it claims that the Ninth Circuit "injected an erroneous conception of facial challenges into its view of the relevant substantive test." Pet. Br. at 16 (*PPFA*). The government first seems to use the phrase "facial challenge" to discuss whether facial invalidation is appropriate, *id.* (referencing *Salerno*'s "no set of circumstances" test and *Casey*'s "large fraction" test), but then employs that phrase in the third sense, to discuss whether a particular plaintiff can bring a challenge based on certain facts that she alleges, *id.* at 17.

[11] The government seizes on the Ninth Circuit's use of the phrase "no circumstance exists" in its enunciation of the substantive standard for evaluating abortion restrictions that lack a health exception. Pet. Br. at 16-17 (*PPFA*) (citing *PPFA*, 435 F.3d at 1172 ("*Stenberg* holds that an abortion regulation that fails to contain a health exception is unconstitutional except when there is a medical consensus that no circumstance exists in which the procedure would be necessary to preserve a woman's health."). The government claims that by using this phrase, the Ninth Circuit "injected an erroneous conception of facial challenges into its view of the relevant substantive test." *Id.* at 16. In other words, the government implies that the Ninth Circuit turned *Salerno* on its head by suggesting that a plaintiff could obtain total invalidation of a statute simply by proving one unconstitutional application. But this is not what the court did: in the passage the government cites, the court analyzed whether the Act violated the Constitution under *Stenberg*, not whether the Act should be facially invalidated on the basis of that violation. *PPFA*, 435 F.3d at 1172 (citing *Stenberg*, 530 U.S. at 937); *see also, e.g.*, *Ayotte*, 126 S. Ct. at 967 (finding constitutional violation where "some very small percentage" of circumstances exists in which minors "need immediate abortions to avert . . . damage to their health"). Thus, unlike the government, *see supra* at 5-10, the Ninth Circuit analyzed the constitutional violation of the Act *separately* from the remedy. *See*

(enunciating standard for evaluating whether the Act's lack of a health exception rendered the Act constitutionally infirm).

The government suggests that based on the Ninth Circuit's ruling, a hypothetical plaintiff who does not claim her health is jeopardized by the Act could somehow obtain facial invalidation of the Act after demonstrating that it would endanger the health of *another* woman. Pet. Br. at 17 (*PPFA*). This is wrong: such a challenge would be dismissed for lack of Article III standing because the plaintiff could not prove that she suffered injury-in-fact. *See H.L. v. Matheson*, 450 U.S. 398, 405-07 (1981) (minor plaintiff, who did not allege that she was mature or emancipated, lacked Article III standing to challenge parental notification statute as to minors who were mature or emancipated) (cited by the government, Pet. Br. at 17 (*PPFA*), notwithstanding that *H.L.* demonstrates the fallacy of the government's hypothetical scenario). This hypothetical situation is irrelevant where, as here, Respondents have Article III standing[12] – because they suffer injury-in-fact – and may, consistent with prudential concerns, raise the constitutional rights of their patients harmed by the Act. *See Singleton v. Wulff*, 428 U.S. 106, 112-13 (1976) (physician plaintiffs suffer "concrete injury from operation of the challenged statute"); *Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 440 n.30 (1983) (holding physician plaintiffs have standing and may raise rights of patients, and distinguishing physician's standing from minor plaintiff's lack of standing in *H.L.*), *rev'd in part*

PPFA, 435 F.3d at 1184-91 (after holding Act unconstitutional, the court fashioned a remedy).

[12] Neither the government nor any court has ever suggested otherwise.

on other grounds by Casey, 505 U.S. 833; *see also Casey*, 505 U.S. at 845 (implicitly recognizing Article III and third-party standing of clinics challenging abortion restrictions to raise the claims of their patients).

The government also claims that "this Court has repeatedly upheld applications of abortion regulations *to particular plaintiffs* while still recognizing the potential for other, unconstitutional applications." Pet. Br. at 17 (*PPFA*) (emphasis added); *see also* Pet. Br. at 19-20 (*Carhart*). While it is true as a general principle that a court can uphold applications of a statute to a particular plaintiff, that assertion is irrelevant where, as here, the plaintiffs have proved that the law would violate their rights and their patients' rights. Moreover, with the exception of *Connecticut v. Menillo*,[13] none of the cases the government cites in fact upholds a statute's application to certain plaintiffs. As noted above, the *H.L.* holding on which the government relies relates to standing. *See* Pet. Br. at 17 (*PPFA*) (citing *H.L.*, 450 U.S. at 405-07). In both *Ohio v. Akron Center for Reproductive Health* (*Akron II*), on which the government relies, *see* Pet. Br. at 20 (*Carhart*); Pet. Br. at 17 (*PPFA*), and *Rust v. Sullivan*, on which its *amici* rely, Br. of the States of Texas, et al. at 23 (*Carhart*); Br. of the Christian Medical and Dental Associations, et al. at 12 (*PPFA*), the Court engaged in constitutional avoidance: it ruled against the plaintiffs by construing the challenged laws so as to avoid constitutional

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[13] *Connecticut v. Menillo*, 423 U.S. 9 (1975), is entirely consistent with the Court's decision in *Ayotte*. The Court in *Menillo* held that Connecticut's pre-*Roe v. Wade* criminal abortion statute could be applied to a non-physician who performed an abortion. *Id.* at 11. Limiting the statute's application to non-physicians involved line drawing that was not "inherently complex." *Ayotte*, 126 S. Ct. at 968.

difficulties,[14] with no indication that the outcome would have been different had the same case, before the statute was enforced, been brought by different plaintiffs.[15] *See, e.g.*, Dorf, *Facial Challenges to State and Federal Statutes*, 46 Stan. L. Rev. at 273 (*Akron II* holding and Justice O'Connor's concurrence in *Webster* rested on constitutional avoidance). Similarly, in *Simopoulos v. Virginia*, 462 U.S. 506, 510 (1983), also cited by the government, Pet. Br. at 17 (*PPFA*); Pet Br. at 20 (*Carhart*), the failure of the constitutional claims was wholly unrelated to the standard for facial challenges: it related instead to defective pleading. In that case, the criminal defendant failed to articulate an adequate basis for his challenge to the abortion statute under which he was charged, and the Court also rejected the claim

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[14] *Akron II*, 497 U.S. 502, 513-14 (1990) (rejecting claim that judicial bypass in parental consent law was constitutionally inadequate because plaintiffs' statutory interpretation – that bypass could take twenty-two days – was unsupported and ignored provision permitting minor to request expedited proceedings); *Rust*, 500 U.S. at 195 (rejecting plaintiffs' challenge because the Court construed the regulation to avoid constitutional problem that would arise from prohibiting referrals for life-saving abortions in federally funded clinics); *see also Webster v. Reprod. Health Servs.*, 492 U.S. 490, 523-24 (1989) (O'Connor, J., concurring in part and concurring in the judgment) (rejecting plaintiffs' interpretation that "the State *could try* to enforce the ban" on using a "*public facility*" for abortions "against *private* hospitals using public water and sewage lines, . . . equipment or . . . land," where "straightforward" applications of the ban were constitutional (emphases added)).

[15] Though the Court in *Akron II* did not "uph[o]ld applications" of the statute at issue "to particular plaintiffs," as the government claims, Pet. Br. at 17 (*PPFA*), it left open the possibility of a challenge based on unconstitutional enforcement of the statute. 497 U.S. at 514. While unconstitutional enforcement of a statute is encompassed in one meaning of the phrase "as-applied challenge," *see supra* at 14 n.10, that is not the meaning that the government employs in its discussion of *Akron II*. *See* Pet. Br. at 17 (*PPFA*).

that his indictment was constitutionally deficient. *Id.* at 509, 517-18. Thus, there is no support for the government's claim that the Ninth Circuit altered the standard for facial challenges, or that this Court's prior abortion jurisprudence has "routinely" upheld abortion regulations as applied to particular plaintiffs.

CONCLUSION

For the reasons set forth above, and in the Briefs for the Respondents, the Court should affirm the judgments of the courts of appeals.

Respectfully submitted,

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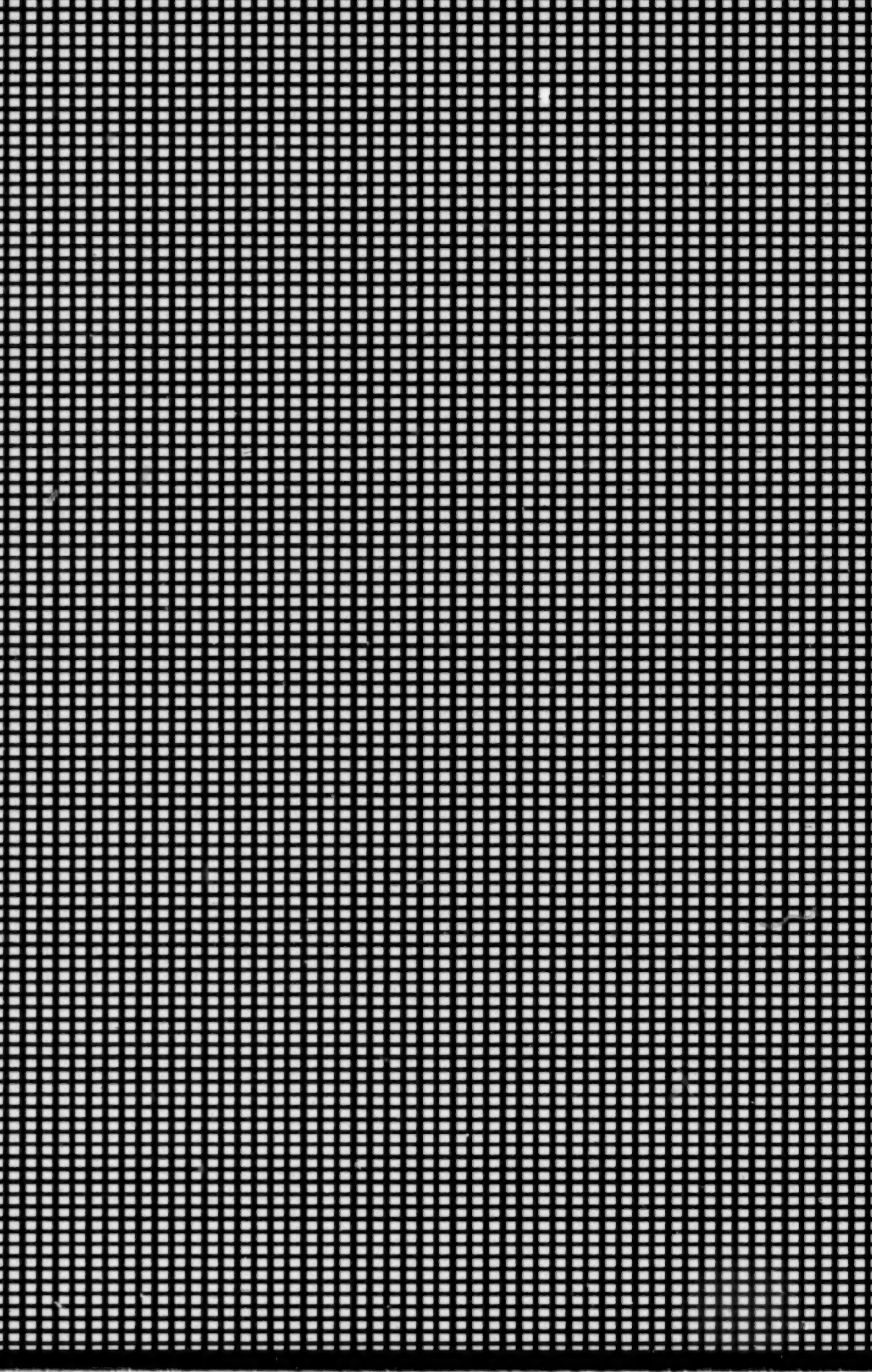

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ALBERTO R. GONZALES, ATTORNEY GENERAL, *Petitioner*,

v.

LEROY CARHART, ET AL., *Respondents*.

ALBERTO R. GONZALES, ATTORNEY GENERAL, *Petitioner*,

v.

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., ET AL., *Respondents*.

On Writs Of Certiorari To The United States Courts Of Appeals For The Eighth and Ninth Circuits

BRIEF OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS AS *AMICUS CURIAE* SUPPORTING RESPONDENTS

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STATEMENT OF INTEREST[1]

The American College of Obstetricians and Gynecologists ("ACOG") is a non-profit educational and professional organization founded in 1951. ACOG is the leading professional association of physicians who specialize in the health care of women. Its more than 50,000 members represent approximately 90% of all board-certified obstetricians and gynecologists practicing in the United States.

ACOG represents the vast majority of physicians affected by the Partial-Birth Abortion Ban Act of 2003 ("the Act"). Though their views on abortion differ, ACOG's members agree that their chief goal is to improve women's health by providing their patients with the safest possible care. As a result, ACOG opposes laws, such as the Act, that would expose patients to serious, unnecessary health risks.

INTRODUCTION

ACOG has consistently opposed bans such as the Act because they endanger women's health. While the Act threatens a broad array of safe abortion procedures used after the first trimester of pregnancy, the Act would endanger women even if—as the Government sometimes asserts—it reached only dilation-and-evacuation procedures in which the physician removes the fetus intact ("intact D&Es").

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[1] No counsel for a party authored any portion of this brief, and no person other than *Amicus* and its counsel contributed any money to the preparation or submission of this brief. *See* Rule 37.6. Letters of consent to the filing of this brief have been lodged with the Clerk of the Court. *See* Rule 37.3.

In defending the Act, the Government repeats Congress's finding that an intact D&E is "never medically indicated to preserve the health of the mother." *See Carhart* Pet'r Br. 2; *PPFA* Pet'r Br. 2. This core premise is, however, medically incorrect. The safety advantages of intact D&E include fewer insertions of instruments into the uterus, reduced risk of perforation, reduced likelihood of retained fetal tissue, reduced blood loss, and shorter time of anesthesia exposure. These safety advantages are particularly significant for women who suffer from serious medical conditions.

The averted harms are not "marginal," as the Government asserts, and include massive hemorrhaging, serious infection, and subsequent infertility. Indeed, after considering the issue in depth, ACOG concluded that intact D&E procedures "may be the best or most appropriate . . . in a particular circumstance to save the life or preserve the health of a woman." *Carhart* J.A. 976 (1997 ACOG Statement of Policy).[2]

The medical advantages of D&Es involving intact removal are now widely acknowledged. As reflected by hearings before Congress and in the courts, the safety advantages of the intact variant are recognized by an array of skilled physicians with impeccable credentials and vast clinical experience. These safety advantages are confirmed by leading medical texts and peer-reviewed studies; the curricula of leading medical schools; and even some of the Act's supporters—including the Government's

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[2] "*Carhart* Pet. App." and "*PPFA* Pet. App." refer to the Appendices to the Petitions for Writs of Certiorari filed in *Carhart v. Gonzales* and *Planned Parenthood Federation of America, Inc. v. Gonzales*. "*Carhart* J.A." and "*PPFA* J.A." refer to the Joint Appendices for the two cases. "CA8 App." refers to the *Carhart* Plaintiffs' Appendix in the Court of Appeals. "S.A." refers to the Supplemental Appendix attached to this brief.

own witnesses. Indeed, as medical practice has evolved in the nine years since ACOG first formulated its policy on intact D&E, and in the six years since this Court decided *Stenberg*, the medical consensus about these safety advantages has grown.

Against this backdrop, the consequences of the Act's failure to include an exception for procedures necessary to protect a woman's health are clear. The Act prevents physicians from providing the care that is most likely to avoid potentially catastrophic health outcomes. It thus imposes a risk of increased harms on those women for whom intact D&E would be the safest option.

Moreover, the Act prohibits more than just intact D&Es. The Act's broad scope and vague terms would chill physicians from performing any second-trimester abortion. And the Act would hinder medical advancement by preventing physicians from using their clinical experience to develop safer procedures.

Like all physicians, ACOG's members must both "recognize responsibility to patients first and foremost" and "respect the law." Amer. Med. Ass'n, *Principles of Medical Ethics: Preamble* (June 2001).[3] Because the Act impermissibly forces physicians to choose between those two duties, the decisions of the Courts of Appeals should be affirmed.

STATEMENT OF FACTS

Every time a physician performs an induced abortion or treats a patient experiencing a miscarriage, the goal is the same: to empty the uterus using the safest techniques for the woman. A physician uses the same techniques

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[3] *Available at* http://www.ama-assn.org/ama/pub/category/2512.html.

whether treating a miscarriage or inducing an abortion. Physicians have continuously improved their techniques, such that in the United States an induced abortion is "one of the safest [surgical] procedures in contemporary practice." David A. Grimes & Mitchell D. Creinin, *Induced Abortion: An Overview for Internists*, 149 Annals Internal Med. 620, 623 (2004). Indeed, an induced abortion is many times safer for a woman than continuing a pregnancy through to childbirth. *See, e.g.*, David A. Grimes, *Estimation of Pregnancy-Related Mortality Risk by Pregnancy Outcome, United States, 1991 to 1999*, 194 Am. J. Obstetrics & Gynecology 92, 92-93 (2006). But the risks of abortion increase as pregnancy advances. *See, e.g.*, Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 Obstetrics & Gynecology 729, 732 (2004).

A. Abortion Procedures

1. First-Trimester

Almost 90% of induced abortions are performed in the first trimester of pregnancy. *See* Lilo T. Strauss et al., Nat'l Ctr. for Chronic Disease Prevention, *Abortion Surveillance—United States, 2002*, Morbidity and Mortality Wkly. Rep. Surveillance Summaries, Nov. 25, 2005, at 1, 21 tbl. 6. The first trimester runs through the first 13 weeks of pregnancy, measured from the first day of the last menstrual period ("LMP") before the woman became pregnant.

The great majority of first-trimester abortions are performed using a method called vacuum aspiration (sometimes called suction curettage). *See id.* at 31 tbl. 18. In these procedures, the physician dilates the cervix and inserts a tube called a cannula through the vagina and cervix and into the uterus. Once the cannula is in the uterus, the physician uses suction to empty the uterus.

See A Clinician's Guide to Medical and Surgical Abortion 111-112 (Maureen Paul et al. eds., 1999) ("*Clinician's Guide*").

2. Second Trimester

Dilation and Evacuation. In the second trimester of pregnancy (approximately 13-26 weeks LMP), when vacuum aspiration is no longer effective, over 95% of induced abortions are performed using the method known as dilatation and evacuation ("D&E"). *See* Strauss et al., *supra*, at 31 tbl. 18. Although individual physicians' techniques may vary somewhat, physicians generally begin by dilating the cervix with dilators, which absorb moisture from the woman's cervix and thus widen the opening of the cervix. These dilators are inserted hours to days prior to the evacuation portion of the procedure. The amount of time required for adequate dilatation varies based on factors including the duration of the pregnancy and the number of prior vaginal deliveries. Some physicians also use medications to facilitate dilation. In some cases of miscarriage, the cervix dilates on its own before the physician sees the patient, eliminating the need to initiate dilation before evacuating the uterus.

After the cervix is sufficiently dilated, the patient returns to the physician for the evacuation procedure. *See* Phillip G. Stubblefield et al., *Methods for Induced Abortion*, 104 Obstetrics and Gynecology 174, 179-180 (2004). After suctioning out the amniotic fluid, the physician reaches through the dilated cervix, generally with a clamp or forceps; grasps the fetus with the instrument; and then pulls the fetal part grasped within the instrument out through the cervix and vaginal canal. *See Clinician's Guide*, *supra*, at 133-36. At this point, when the physician starts to withdraw the forceps from the woman's body, the fetus is usually intact. Often, especially earlier in the second trimester, disarticulation

(or dismemberment) occurs as the physician delivers the fetal part grasped in the instrument and pulls it through the opening of the cervix. The physician then reinserts the forceps, and repeats this step until all fetal material has been removed from the uterus. *See id.* The fetus dies sometime during the process of disarticulation.

Physicians try to minimize the number of times they insert instruments into the woman's uterus, and therefore attempt to remove as much of the fetus as possible each time they insert the instrument. In some D&Es, little or no disarticulation occurs, and the physician removes the fetus relatively intact. This reduces instrumentation and therefore reduces the risk of injury to the woman's uterus. Any D&E can result in relatively intact removal of the fetus.

However, as the pregnancy advances, the fetal skull will become too large to pass through the cervix—especially later in the second trimester. Hence, whether the D&E involves extensive disarticulation or relatively intact removal, the fetal skull usually must be compressed to allow it to pass through the cervix without injuring the woman. *See* Warren M. Hern, *Abortion Practice* 199-200 (1984). And in many D&Es, the physician extracts part of the fetus while it retains a heartbeat or other indicia of life, such as a pulsating umbilical cord.

Starting at approximately the mid-point of the second trimester, some physicians more routinely perform D&Es in which the fetus is removed intact (sometimes known as "intact D&E" or the "intact variant"). In one technique, the physician brings the fetus through the cervix intact in a breech position. If the head then lodges in the uterus, it must be compressed to complete the extraction. ACOG has referred to this procedure as intact dilatation and extraction. *See* ACOG Statement of Policy, Abortion

Policy (July 2004), *reprinted in* ACOG, *2006 Compendium of Selected Publications* 1059-61 (2006) (reaffirming Jan. 1997 and Sept. 2000 revisions). In another technique, the physician begins by compressing the skull of a fetus that is presenting head-down—while it is entirely within the uterus. Once the head will fit through the cervix, the physician removes the fetus intact.

Because greater dilation generally increases the likelihood of intact extraction, whether intact extraction will be possible in any given case often depends on how far the cervix has dilated. But physicians cannot predict in which cases they will be able to remove the fetus intact or relatively intact. In most cases, physicians perform dilation on all of their patients the same way and hope to achieve enough dilation to facilitate intact extraction.

Induction. Other than D&E, almost all other induced abortions after the first trimester are performed by the method known as induction. In an induction abortion, the physician induces pre-term labor with potent medications, the cervix dilates, and the fetus is generally expelled through the labor process. The procedure requires constant monitoring and must be performed in a hospital. An induction lasts anywhere from fewer than twelve hours to more than forty-eight hours.

Induction poses specific risks to women with certain medical conditions, and may be entirely contraindicated for others. For example, induction abortions are relatively or absolutely contraindicated for women who have had a previous hysterotomy or cesarean section with a classical (vertical) scar, because they can lead to uterine rupture, hemorrhage, and even death. *See* P. Boulout et al., *Late Vaginal Induced Abortion after a Previous Cesarean Birth: Potential for Uterine Rupture*, 36 Gynecologic & Obstetric Investigation 87, 88 (1993).

In some circumstances in which the induction results in a breech delivery, the fetal skull may be too large to fit through the partially dilated cervix. In such cases, the physician generally must compress the skull to complete the delivery and reduce the likelihood of serious injury to the woman. In the case of an incomplete or unsuccessful induction, the physician must complete the abortion using D&E techniques. *See* Stubblefield et al., *supra*, at 180-81; *Clinician's Guide, supra,* at 151.

Abdominal Surgery. In rare instances, physicians perform abortions via abdominal surgery: hysterectomy (removal of the uterus) or hysterotomy (essentially a pre-term cesarean section). *See Williams Obstetrics* 245 (F. Gary Cunningham et al. eds., 22d ed. 2005) ("*Williams Obstetrics 2005*"). These procedures entail far higher risks for the woman than do either D&E or induction. Compared to the type of incision used for term cesarean deliveries, the incision in the uterus used for a second trimester abortion by hysterotomy has a higher risk of rupture in subsequent pregnancies. Such a rupture in a subsequent pregnancy can cause hemorrhage, loss of the uterus, fetal death, and even the woman's death. And a hysterectomy eliminates a woman's ability to bear children in the future. *See* P. Diggory, *Hysterotomy and Hysterectomy as Abortion Techniques, in Abortion and Sterilization: Medical and Social Aspects* 317, 331 (Jane E. Hodgson ed., 1981).

B. ACOG's Statement of Policy on Intact D&E

In October 1996, ACOG's Executive Board, the governing body that sets policy for the organization, embarked on an effort to develop a policy statement concerning the so-called "partial birth abortion" procedure. A task force convened by the Executive Board reviewed the medical facts surrounding the issue and

drafted a proposed policy statement. The task force consisted of practicing obstetrician-gynecologists, who were "carefully select[ed] . . . based on their expertise and viewpoint"—ACOG "chose" task force members from diverse backgrounds." *Carhart* Pet. App. 424a-25a. Members included, among others, specialists in treating high-risk pregnancies and physicians who regularly performed or oversaw abortions, including intact D&Es. *See id.* at 425a-26a. The task force also included at least one physician who opposed abortion. *See id.* at 425a.

The task force members reviewed materials sent to them in advance and then met over a two day period to review the background literature and discuss specific cases in which the intact variant of D&E might be employed. *See id.* at 426a-33a. As one task-force member testified, there were "multiple circumstances that an expert panel could identify at the time of the task force where [intact D&E] was clearly the best choice, including . . . where the other options led to a higher likelihood of death or recurrence of disease." *Carhart* J.A. 502 (Cain Dep. Test.); *PPFA* J.A. 859 (same). Therefore, the task force concluded that intact D&E could be the safest or most appropriate procedure for a given patient, and that the decision whether to choose such a procedure should be left to a woman and her physician. *See Carhart* Pet. App. 436a. The task force presented this conclusion to ACOG's Executive Board in a draft Statement of Policy.

The Executive Board includes, among others, nationally elected officers, and elected representatives from each of ACOG's nine geographic districts and one district made up of members of the Armed Forces. At the time that ACOG's Executive Board considered the draft Statement of Policy, there were 19 members. The Executive Board approved the draft Statement of Policy, but determined that it should explicitly state the task

force's conclusion that an intact D&E may be the best or most appropriate procedure under certain circumstances.

The Executive Board inserted that conclusion (emphasized below) into its final policy statement which states, in relevant part:

> A select panel convened by ACOG could identify no circumstances under which [intact D&X] . . . would be the *only* option to save the life or preserve the health of the woman. ***An intact D&X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based on the woman's particular circumstances can make this decision.*** The potential exists that legislation prohibiting specific medical practices, such as intact D&X, may outlaw techniques that are critical to the lives and health of American women.

Carhart J.A. 975-976 (second emphasis added). Despite routine turnover of its membership, the ACOG Executive Board reaffirmed the Statement of Policy in September 2000 and again in July 2004. *See* ACOG Statement of Policy, *supra*.

ARGUMENT

I. INTACT D&E IS NECESSARY TO PREVENT SERIOUS HARM.

Over 95% of women terminating a pregnancy in the second trimester undergo a D&E procedure. *See* Strauss et al., *supra*, at 31 tbl. 18. Among D&E procedures, those

in which the fetus is delivered intact, or relatively intact, offer potentially significant safety advantages.

A. Intact D&E Reduces The Risk of the Most Serious Complications of Non-intact D&E.

The intact approach reduces the risk of the most severe complications of D&Es involving dismemberment by minimizing instrumentation and reducing the chances of retained fetal tissue.

First, the intact variant of D&E "minimize[s] instrumentation within the uterine cavity." *Clinician's Guide, supra*, at 136. It thus "facilitates extraction and minimizes uterine or cervical injury from instruments or fetal bones." *Williams Obstetrics 2005, supra*, at 243.

Fewer instrument passes and fewer fetal-bone fragments means less risk of uterine perforation—the most serious and feared complication of D&E. "[A] perforation occurring with second-trimester D&E may lead to bowel injury and will likely require laparotomy [open abdominal surgery]." Stubblefield et al., *supra*, at 180. A perforation that reaches the uterine artery, which is engorged during pregnancy, may cause catastrophic hemorrhage. "Uterine perforations that involve injury to major blood vessels or other organs . . . require in-hospital surgical management." *Clinician's Guide, supra*, at 178. Some uterine perforations can also reach the gastrointestinal tract, risking contamination of the abdominal cavity with bacteria (peritonitis) or entry of bacteria into the blood stream (sepsis). By causing tissue and organ damage, including damage to the brain and

other vital organs, both hemorrhage and sepsis can have long term effects on the woman's health.[4]

Second, removing the fetus intact also eliminates the possibility that fetal tissue will be retained in the uterus, a cause of hemorrhage or infection in non-intact D&E procedures. *See* Stubblefield, et al., *supra*, at 180 ("[h]emorrhage during or after D&E can be caused by an incomplete procedure"); *Clinician's Guide, supra*, at 201 (retained fetal tissue can cause bleeding, infection of the uterus and fallopian tubes, and sepsis). Long-term complications of retained fetal tissue also include infertility.

Third, intact removal increases the physician's control over the procedure. Increased control minimizes the likelihood of complications that are present in other forms of D&E. For example, removing the fetus intact reduces the likelihood that the physician will have to locate the last piece of fetal tissue remaining in the uterus by grasping repeatedly with the forceps—a process that risks injuring the woman. *See* Hern, *supra*, at 194-95.

Finally, emerging study data, confirmed by clinical experience, suggests that intact removal is faster than other methods used at comparable stages of pregnancy. A recent study measured the procedure time for both the intact and non-intact variants. The women who received the intact variant were two weeks later in pregnancy, and

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[4] "Obstetric hemorrhage can be of a volume large enough to precipitate a state of generalized circulatory failure, resulting in . . . irreversible tissue damage." Am. Acad. of Pediatrics & ACOG, *Guidelines for Perinatal Care* 180 (5th ed. 2002). Lungs, kidneys, and the pituitary gland are particularly susceptible to damage from hemorrhagic shock during pregnancy. *See Critical Care Obstetrics* 555 (Gary A. Dildy et al. eds., 4th ed. 2004). Sepsis can result in lung, liver, and kidney failure, damage to the brain and other organs, and even death. *See id.* at 329-31; *Williams Obstetrics 2005, supra*, at 994-95.

thus were expected to require longer procedures. But the intact procedures performed on the later-term women took no longer than the non-intact procedures performed on the earlier-term women—that suggests that all things being equal, intact D&Es are quicker. *See* Stephen T. Chasen et al., *Dilation and Evacuation at ≥ 20 Weeks: Comparison of Operative Techniques*, 190 Am. J. Obstetrics & Gynecology 1180, 1180-03 (2004). The shorter the procedure lasts, the less the blood loss, trauma, exposure to anesthesia, and risk of serious complications.

B. Intact D&E Is Safest For Women With Certain Conditions.

Intact removal offers particularly significant benefits for women suffering from certain medical conditions that make the potential complications of non-intact D&E especially grave. Hemorrhage, infection, and prolonged surgical intervention present particular risks for women with chronic medical conditions such as bleeding disorders, heart disease, or compromised immune-systems. The intact variant is also significantly safer for women with certain pregnancy-related conditions.

1. Intact D&E is Safest for Women with Placenta Previa and Accreta.

For some women with placenta previa, the intact variant minimizes the chance of hemorrhage. In this condition, the placenta partially or entirely covers the cervical opening, creating a risk of excessive bleeding when the cervix is dilated. *See Emergency Medicine: Concepts and Clinical Practice* 2377 (Peter Rosen et al. eds., 1998); *Williams Obstetrics 2005*, *supra*, at 819-820. Bleeding occurs when the placenta separates from the cervix and the uterine wall, and the bleeding cannot be controlled until after the uterus is emptied. While a

woman with placenta previa will begin to bleed in any D&E procedure when the cervix is dilated, causing the placenta to begin to separate, intact removal minimizes the risk of excessive bleeding and hemorrhage by reducing instrumentation and manipulation near the bleeding placenta. *See Carhart* J.A. 523 (Broekhuizen Trial Test.); *PPFA* J.A. 266-267 (same); *Carhart* J.A. 888 (Westhoff Trial Test.). In addition, because the intact variant can be performed more quickly than the non-intact technique, the bleeding can be controlled sooner and the risk of excessive bleeding is lower. Induction is absolutely contraindicated in cases of placenta previa because the lengthy process of the labor and delivery would result in life-threatening hemorrhage.

The intact variant may also be safest for women suffering from placenta accreta. Women with placenta accreta, which occurs when the placenta abnormally invades the wall of the uterus, may benefit from a procedure that minimizes the use of instruments in the uterine cavity. Such a procedure is less likely to disrupt the placenta and cause life-threatening hemorrhage. *See PPFA* J.A. 511-514 (Chasen Trial Test.).

2. Intact D&E is Safest for Women with Chorioamnionitis.

Intact D&E reduces the risk of harm to a patient with chorioamnionitis, a bacterial infection of the fetal membranes. The infection spreads rapidly to the fetus, placenta, and uterine wall, and eventually spreads to other pelvic organs, resulting in peritonitis and sepsis.

Even in the early stages of this condition, antibiotics cannot effectively treat the condition unless the uterus is also emptied of the pregnancy tissue. Thus, because it allows the physician to remove the fetus more quickly, the intact variant allows physicians to treat the infection

earlier and prevent its spread. The intact variant's lower risk of uterine perforation likewise helps prevent the infection from spreading beyond the uterus. Indeed, intact removal is also preferable if the woman has other infections because, as ACOG's Dr. Cain testified, "any increase in instrumentation might increase the ability of the bacteria to enter the blood stream." *Carhart* J.A. 507; *PPFA* J.A.1110.

These advantages were recognized even by one of the Government's experts. Dr. Lockwood testified that intact D&E might be advantageous for women with chorioamnionitis because the infection may have thinned or damaged the uterus. See *Carhart* J.A. 424-25. Other witnesses agreed that in those circumstances, "an intact D&E would be the optimal way to empty the uterus," because it decreases the risk of cervical laceration and hemorrhage, which are among the most common complications of D&E. *Carhart* J.A. 711-13 (Frederiksen Trial Test.); *see also id.* at 768, 770-71 (Hammond Trial Test.); *id.* at 124-25 (Vibhakar Trial Test.) (induction abortion is contraindicated for a woman with chorioamnionitis).

3. Intact D&E is Safest for Women with Certain Fetal Abnormalities.

Intact D&E may also be the safest procedure for a woman whose fetus has certain abnormalities—such as severe hydrocephalus, a greatly enlarged head—that make extraction difficult. The intact variant allows a doctor to reduce the size of the abnormally large head before it passes through the cervix—thereby reducing the risk of injury to the cervix. *See Carhart* J.A. 595 (Chasen Trial Test.). As recognized by the AMA task force—whose members included the Government's expert Dr. Sprang—intact D&E may be preferred "when the fetus has been diagnosed with hydrocephaly or other anomalies

incompatible with life outside the womb." *PPFA* J.A. 670-671 (Sprang Trial Test.).

C. The Safety Benefits of Intact D&E Are Significant.

The Government repeatedly and incorrectly asserts that the medical benefits of D&E involving intact removal are insignificant, and thus that the risks imposed by banning such procedures are "marginal." *See Carhart* Pet'r Br. iv, 10, 14, 37, 39, 40, 42; *PPFA* Pet'r Br. 10, 24, 27-29. This argument misunderstands how doctors evaluate risk. It is a significant safety advantage where a procedure reduces the risk of a potentially catastrophic complication. And a ban on that procedure correspondingly places patients at significant risk by depriving them of the treatment that is most likely to help them avoid a tragic outcome.

Likewise, though complications from the non-intact variant are (fortunately) rare, the Government "cannot prohibit a person from obtaining treatment simply by pointing out that most people do not need it." *Stenberg v. Carhart*, 530 U.S. 914, 934 (2000). Denying women access to a procedure that could reduce those infrequent disastrous outcomes—especially women faced with the medical conditions described above—subjects them to real increased risk of serious harm.

It is thus medically incorrect to dismiss, as the Government does, the safety advantages of the banned procedures as "marginal."

II. A MEDICAL CONSENSUS RECOGNIZES THAT INTACT D&E OFFERS HEALTH BENEFITS.

The safety advantages of intact D&E are widely recognized—in medical texts, peer-reviewed studies, clinical practice, and even by some of the Government's own witnesses. This broad collection of medical authority contradicts the Government's claim that only a "minority of medical professionals" recognize that a ban on intact D&E would subject women to significant health risks. *Carhart* Pet'r Br. 9; *PPFA* Pet'r Br. 10. These safety advantages are even more widely accepted today than they were six years ago, when this Court decided *Stenberg*. And they were apparent in the record that Congress considered in passing the Act.

A. Authoritative Texts and Peer-Reviewed Articles

The intact variant and its safety advantages are recognized in authoritative medical texts and articles in peer-reviewed journals. A leading textbook on abortion methods describes the intact variant and suggests that it is safer because it reduces the need for insertion of instruments into the uterus. *See Clinician's Guide, supra,* at 136-37; *see also* Phillip G. Stubblefield, *First and Second Trimester Abortion, in Gynecologic, Obstetric, and Related Surgery* 1033, 1043 (David H. Nichols & Daniel L. Clarke-Pearson eds., 2d ed. 2000) (confirming that intact D&E is a recognized variant of D&E). The year after this Court decided *Stenberg*, *Williams Obstetrics*, another authoritative text in the field, recognized that the intact D&E is a variant of the D&E procedure. *See Williams Obstetrics* 871 (F. Gary Cunningham et al. eds., 21st ed. 2001). In 2005, *Williams Obstetrics* observed that the intact variant "facilitates extraction and minimizes uterine or cervical

injury from instruments or fetal bones." *Williams Obstetrics 2005*, *supra*, at 243.

Articles in leading, peer-reviewed medical journals also describe the intact variant of D&E and confirm the benefits of this "further evolution" of the D&E technique. Stubblefield et al., *supra*, at 179. For instance, a peer-reviewed study published in 2004 by Dr. Stephen T. Chasen of Cornell University suggests that intact D&E is safer than its alternatives. Dr. Chasen compared women who underwent non-intact procedures with those who underwent relatively intact procedures. *See* Chasen et al, *supra*, at 1181. Though the overall complication rates in the two groups were comparable, all of the serious complications were suffered by women who underwent the non-intact variant. *See id.* at 1182.

Moreover, the patients in the intact group had been pregnant longer. *See id.* at 1183. As the Government's Dr. Lockwood testified, the patients with longer pregnancies would have been expected to suffer higher rates of more serious complications. *See Carhart* J.A. 435, 440. That the women in the intact D&E group did not suffer such higher rates of more serious complications suggests that the intact procedures were at least as safe as, and likely safer than, the non-intact alternative.

B. Medical Schools

Since this Court decided *Stenberg*, even more leading medical schools have started to teach the intact method of D&E. Among the schools that now teach the intact variant are Columbia, Cornell, Yale, New York University, Northwestern, University of Pittsburgh, University of Pennsylvania, University of Rochester, and University of Chicago. This evidence flatly contradicts Congress's finding that "no medical schools . . . provide

instruction" in D&E with intact removal. *Carhart* Pet. App. 595a (Act § 2(14)(B)).

Even the Government's expert, Dr. Lockwood, testified that he intended to establish a program that would teach intact D&E at Yale, where he chairs the Department of Obstetrics and Gynecology. *See Carhart* J.A. 406-07 (Lockwood Trial Test.). Yale now teaches the intact variant.

C. Medical Associations

The intact variant's safety advantages are also recognized by leading medical associations. ACOG's own position on the intact variant, as reflected in its 1997 Statement of Policy, reaffirmed most recently in July 2004, belies the Government's claim that only a small minority of physicians assert the safety advantages of intact removal in a D&E. ACOG, which represents more than 90% of all board-certified obstetricians and gynecologists practicing in the United States, has concluded that intact D&E "[m]ay be the best or most appropriate procedure to save the life or preserve the health of a woman." *Carhart* J.A. 976 (1997 ACOG Statement of Policy).[5]

That ACOG "could identify no circumstances under which this procedure . . . would be the *only* option to save the life or preserve the health of the woman," *see id.* at 975-976 (emphasis in original), is in no way inconsistent with the proposition that intact D&E may be medically necessary in some cases to avoid significant risks to the

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[5] *See also Partial-Birth Abortion Ban Act of 2003: Hearing on H.R. 760 Before the House Subcomm. on the Constitution of the Comm. on the Judiciary*, 108th Cong. 197 (2003) (2002 ACOG statement) ("there are circumstances under which intact D&X would be the most appropriate and safest procedure to save the life or health of a woman").

woman. While other abortion techniques may be available to terminate a particular woman's pregnancy, the intact variant may be the *safest* method for that woman.

Other leading medical associations agree. The American Medical Women's Association has concluded that D&E with intact removal is "in some circumstances . . . the safest and most appropriate alternative available to save the life and health of the woman." *See Partial-Birth Abortion Ban Act of 2003: Hearing on H.R. 760 Before the House Subcomm. on the Constitution of the Comm. on the Judiciary*, 108th Cong. 201 (2003) ("*2003 Hearing*"). The American Public Health Association takes a similar position. *See* 149 Cong. Rec. S12931 (daily ed. Oct. 21, 2003) (statement of Sen. Boxer).

D. Congress's "Findings" Are Contradicted by Its Own Record and the Medical Evidence.

Despite this medical consensus and the inclusion of intact D&E within mainstream care, the Government argues that this Court must defer to Congress's "findings" that intact D&E is never medically necessary. After reviewing the medical evidence before Congress, ACOG agrees with the District Court in *Carhart* that "the congressional record disproves the Congressional Findings." *Carhart* Pet. App. 464a.

Congress claimed that the procedure is disfavored "particularly among physicians who routinely perform other abortion procedures." *Id.* at 590a (Act §2(2)). Precisely the opposite was true: The National Abortion Federation, Planned Parenthood, and ten physicians with recent surgical-abortion experience all described the safety advantages of an intact approach to D&E. For example, Dr. Anne R. Davis stated that "there is no

question that intact D&E is a safe abortion procedure that may well be the safest procedure for some women in certain circumstances." 2003 Hearings, *supra*, at 191-195. Dr. J. Courtland Robinson stated that "sometimes it is necessary to deliver the fetus intact to perform the safest method of abortion." *Carhart* Pet. App. 69a. And Dr. Samuel Edwin stated that intact D&E "is the safest option for many women faced with medical emergencies during pregnancy," 141 Cong. Rec. S18192 (daily ed. Dec. 7, 1995) (statement of Sen. Levin). A chorus of other doctors echoed these statements.

Also squarely contradicted is Congress's finding that the intact variant actually harmed the health of women. Even the Government's experts conceded that there was no evidence to support Congress's finding that the intact variant increased the risk of "uterine rupture, abruption, amniotic fluid embolus, and trauma to the uterus." *See, e.g., PPFA* J.A. 727 (Shadigian Trial Test.); *id.* at 781 (Cook Trial Test.).

The medical evidence also fails to support Congress's finding that intact D&E increases a woman's risk of cervical incompetence, which can cause pre-term birth in subsequent pregnancies. *See Carhart* Pet. App. 594a-95a (Act § 2(14)(A)). Two different studies have found that dilation in a non-intact D&E procedure is not associated with cervical incompetence. *See* Kalish et al., *Impact of Mid-Trimester Dilation and Evacuation on Subsequent Pregnancy Outcome*, 187 Am. J. Obstetrics & Gynecology 882 (2002); Schneider et al., *Abortion at 18-22 Weeks by Laminaria Dilation and Evacuation*, 88 Obstetrics & Gynecology 412 (1996). The dilation protocol is the same for both intact and non-intact procedures. Moreover, Dr. Chasen's follow-up study in 2005 concluded that, contrary to the findings of Congress and the testimony of some of the Government's witnesses, those who received intact D&E did not suffer higher rates of spontaneous, preterm

birth in future pregnancies. *See* Stephen T. Chasen et al., *Obstetric Outcomes After Surgical Abortion at ≥ 20 weeks' gestation*, 193 Am. J. Obstetrics & Gynecology 1161, 1163 (2005).

The Government's own witness perhaps best sums up the reliability of the congressional findings. Dr. Watson A. Bowes, Jr., who supports the ban and has never opposed any abortion restriction, testified at trial that had anyone in Congress sought his opinion, he would have advised Congress that the findings were inaccurate. *See PPFA* Pet. App. 195a. As Dr. Bowes stated, Congress's findings "cannot be supported by evidence-based medicine." CA8 App. 285.

III. THE ACT WILL CHILL DOCTORS FROM PROVIDING SECOND-TRIMESTER ABORTIONS.

Because the Act is both vague and broad, it will chill doctors from providing a wide range of procedures used to perform induced abortions or to treat cases of miscarriage. This chill will extend well beyond those procedures that the Act purports to target.

First, the terms of the Act are ambiguous and foreign to the actual practice of medicine. As Dr. Carolyn Westhoff of Columbia testified at trial in *National Abortion Federation v. Ashcroft*,[6] another lawsuit challenging the constitutionality of the Act, "it's really difficult for me to tell when I am actually doing a case exactly whether I would be violating the ban." S.A. 11a. Confirming the validity of Dr. Westhoff's concerns, the Government's expert Dr. Lockwood conceded that before

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[6] 330 F. Supp. 2d 436 (S.D.N.Y. 2004), *aff'd*, 437 F.3d 278 (2d Cir. 2006).

speaking to "counsel for the government, [he] believed that the Act's language was so imprecise that it just doesn't prohibit intact D&Es but also threatens all abortions." *Id.* at 12a.

For one, "partial-birth abortion" is not a medical term: neither medical textbooks nor physicians use the term to define any particular procedure. *See 2003 Hearing*, *supra*, at 1. The Act exacerbates this problem by defining "partial-birth abortion" with terms that are themselves confusing. "Overt act," for example, could describe many of the steps that physicians take in any D&E or induction, such as severing the umbilical cord, separating a fetal part from the remainder, or compressing a part of the fetus that cannot otherwise pass through the cervix.

Moreover, though the Government asserts that the Act targets intact D&Es, the word "intact" does not appear in the Act. Remarkably, the Government has defended that omission on the grounds that including the word "intact" would create an "obvious loophole." S.A. 7a. Physicians cannot confidently treat their patients given these mixed signals.

This confusion is amplified by discrepancies between the Act's "Findings" and its operative language. For example, the Findings state that in a so-called partial-birth abortion, the physician "deliver[s] all but the head out of the womb." *Carhart* Pet. App. 597a (Act § 2(14)(J)). But to trigger the ban, the physician need deliver from the womb only "any part of the fetal trunk past the navel." *Id.* at 599a (Act § 3(a)). The Findings also refer to "converting" the fetus to a "breech position"; state that "labor is induced"; and describe "the doctor blindly forcing a sharp instrument into the base of the" fetal skull. *Id.* at 594a, 596a (Act § 2(14)(A) & (H)). But the ban includes no such elements, or anything like them. *See id.* at 599a

(Act § 3(a)). As one doctor explained, "I don't know if what is banned necessitates that I do those actions listed in the findings or not." S.A. 10a.

Second, the Act's scienter requirements only compound its vagueness. For example, the Act purports to target only procedures in which the physician delivers a certain portion of the fetus "for the purpose of performing an overt act the [physician] knows will kill the . . . fetus." *Carhart* Pet. App. 599a (Act § 3(a)). But the state-of-mind identified in the Act is not limited to intact D&Es. To the contrary, a physician begins a D&E with the intent of removing the fetus as intact as possible—but does not know whether intact removal will be possible or when fetal demise will occur.

Similarly, a physician begins every D&E intending to perform acts necessary to evacuate the uterus in a way that is safe for the woman. The physician also knows that such acts, which include cutting the umbilical cord or dismembering or compressing a fetal part, will result in fetal demise. Thus, in any D&E or induction procedure where part of the fetal trunk past the navel is outside the uterus, the physician will commit an "overt act" if necessary to complete the safe evacuation of the uterus.

As a result of these ambiguities, the Government's expert Dr. Lockwood testified that the Act could well be construed to "outlaw all D&Es." CA8 App. 489.[7] Even the Government essentially concedes that any D&E procedure might be covered by the Act. *Carhart* Pet'r. Br. 47 ("Where . . . a physician delivers . . . any part of the trunk past the navel . . . and then performs a discrete act that aborts the fetus, the procedure constitutes a 'partial-

[7] Another Government witness, Dr. Cook, recognized that Congress could have more narrowly tailored the Act to reach only intact D&E procedures. *See Carhart* Pet. App. 515a; CA8 App. 419-20.

birth abortion,' in the literal sense of the phrase, rather than a [non-intact D&E] regardless of whether the ultimate lethal act is . . . dismemberment.").

Indeed, when beginning any D&E, the physician knows that the safest way to proceed may well be to perform each of the steps in the Act's definition. *See Carhart* J.A. 52-53 (Doe Trial Test.), *id.* at 143 (Vibhakar Trial Test.), *id.* at 205-208 (Knorr Trial Test.). In every D&E and induction abortion, the physician "deliberately and intentionally" extracts the fetus from the uterus through the vaginal canal. *See Carhart* J.A. 108-09 (Fitzhugh Trial Test.). Likewise, the first time the physician inserts instruments into the woman's body, grasps part of the fetus, and withdraws the instrument, the physician may remove the fetus until part of the fetal trunk past the navel is outside the woman's body. Or, on the first pass with instruments, the physician may disjoin a leg from the rest of the fetus, and then, on the second pass, remove the fetus until part of the fetal trunk past the navel is outside the woman's body. In either of the previous two scenarios, these steps may occur—for a "living fetus" need not be intact. *See id.* at 109-11; *Carhart* Pet. App. 517a. Finally, in either scenario, if the remainder of the fetus within the uterus obstructs continued extraction, the physician would commit an "overt act," such as disjoining the part of the fetus outside the uterus, or compressing the fetal part that is obstructing delivery. In either scenario, that may occur before fetal demise.

The Act could also extend to inductions. For example, sometimes during an induction, the fetus is not fully expelled within a reasonable time, or the woman develops health complications (including hemorrhage and infection) before the procedure can be completed. In these situations, the physician must complete the fetal evacuation using instruments, and may violate the Act for

all the same reasons that a physician might violate the Act while performing a D&E. *See* Carhart J.A. 467-468 (Lockwood Trial Test.). In other instances, such as when the fetus has severe hydrocephalus, the fetal head is too large to pass through the woman's cervix. In this circumstance, the physician must reduce the size of the head to extract the fetus, and thus must perform an "overt act" that may kill the fetus. *See Carhart* J.A. 110-111 (Fitzhugh Trial Test.). One Government witness acknowledged that a doctor in that situation would face "the possibility of being charged." CA8 App. 363 (Sprang Trial Test.).

The Act's chilling effect is manifest. As Drs. Michael Greene and Jeffrey Ecker explained soon after the passage of the Act, physicians who performed non-intact D&Es feared "that the wording of the current bill is sufficiently imprecise that the procedures they are now doing could be construed to meet the criteria of the banned procedure." Michael Greene & Jeffrey Ecker, *Abortion, Health and the Law*, New Eng. J. Med. 350:2, Jan. 8, 2004, at 178. Dr. Paul Blumenthal similarly warned:

> None of my colleagues know or could state whether the abortion procedures they now perform are covered under this law. Indeed, as I read the definition of the banned procedures, any of the safest, most common abortion methods used throughout the second-trimester of pregnancy could proceed in such a manner as to be outlawed.

Paul Blumenthal, *The Federal Ban on So-Called "Partial-Birth Abortion" is a Dangerous Intrusion into Medical Practice*, Medscape Gen. Med., June 25, 2003, http://www.medscape.com/viewarticle/457581.

To so chill the provision of the only safe options for second-trimester abortion—D&E and induction—places an "undue burden" on the right to reproductive choice. It also gravely endangers the health of women in this country.

IV. THE ACT WILL HINDER IMPROVEMENTS IN PATIENT SAFETY.

The Act also stifles physicians' ability to develop and vary techniques to increase safety for women. Such exploration and variation of known techniques led to the most common, safest abortion methods used today. *See Carhart* J.A. 163-164 (Howell Trial Test.). This Court has long recognized that "present medical knowledge" changes, *see City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 437 (1983), and that bans on abortion methods threaten to stymie medical advancement. Thus, in *Planned Parenthood v. Danforth*, the Court invalidated a broad ban on saline instillation because, among other things, the statute threatened to preclude "methods that may be developed in the future and that may prove highly effective and completely safe." 428 U.S. 52, 78 (1976). The Act at issue here also interferes with medical evolution and thus violates a guiding principle of this Court's prior abortion rulings.

For instance, physicians developed the vacuum-aspiration procedure as a safer alternative to dilatation and curettage ("D&C"), which was slower, less thorough, and caused more complications. *See* Pak Chung Ho, *Termination of Pregnancy Between 9 and 14 Weeks, in Modern Methods of Inducing Abortion* 54, 56-57 (David T. Baird et al. eds., 1995). Although vacuum aspiration had been described in medical literature for over a hundred years, it was not until abortion was legalized nationwide in 1973 that physicians were able to develop and perfect these techniques. *See Clinician's Guide*, *supra*, at 5-6,

107-08. Vacuum aspiration is now by far the most common method of first-trimester abortion. *See id.* It is also incredibly safe.

Later, the D&E procedure was developed when physicians experimented with ways to extend first-trimester surgical techniques to the second trimester. Physicians did so in the 1970s and 1980s, seeking an option safer than induction abortions, which were then the only method of second-trimester abortion short of abdominal surgery. In addition to requiring hospitalization, often over days, the induction method known at the time did not work before 16 weeks LMP. This meant that any woman past 12 weeks LMP had to wait—up to four weeks—until an induction was feasible. *See* Eugene Glick, *Surgical Abortion* 46-48 (1998).

Today, D&Es account for 95% of second-trimester abortions, and D&Es have essentially eclipsed inductions. Most of the credit for the rapid improvement in D&E techniques belongs to physicians who, over the years, have tested slightly varying techniques and have shared their discoveries with their colleagues. *See id.* And as this Court has recognized, the development of D&E was ultimately responsible for the remarkable improvements in the safety of post-first-trimester abortion that have occurred since *Roe*. *See Akron*, 462 U.S. at 435-37. One of the reasons D&E safety has itself improved so markedly is that physicians continue to innovate, using slightly varying techniques, and have taught the improved techniques to colleagues. *See, e.g.*, Glick, *supra*, at 47.

The growing prevalence of intact D&Es represents the continued evolution of the longstanding D&E method. Physicians have long recognized the safety advantages of minimizing the number of times they insert instruments into the patient's body, and physicians have long known

that intact extraction sometimes occurs. Through the intact variation, physicians simply try to increase the likelihood that this will occur for any given procedure, and they do this for one reason and one reason only: to minimize medical risk for their patients. *See Clinician's Guide*, *supra*, at 136.

If physicians are permitted to perform and improve the variant through clinical experience, these improvements may further advance medical knowledge and make abortion safer. If allowed to stand, the Act would stifle clinical progress, prevent further, peer-reviewed study of intact D&E, and cause immeasurable loss to women and their families.

CONCLUSION

For the preceding reasons, the judgments of the Courts of Appeals should be affirmed.

Respectfully submitted,

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UNITED STATES DISTRICT COURT, D. NEBRASKA

LEROY CARHRAT, M.D., WILLIAM G. FITZHUGH, M.D., WILLIAM H. KNORR, M.D., AND JILL L. VIBHAKAR, M.D., *Plaintiffs*,

v.

JOHN ASHCROFT, IN HIS OFFICIAL CAPACITY AS ATTORNEY GENERAL OF THE UNITED STATES, *Defendant*.

No. 4:03CV3385.

November 4, 2003.

Defendant's Opposition to Plaintiffs' Motion for a Temporary Restraining Order

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[EXCERPT]

a) The Partial-Birth Abortion Procedure is Plainly Distinct from the Dilation and Evacuation Method of Abortions.

Plaintiffs present a series of assertions that deliberately intermix the terms of the Act, such as "living" fetus, "outside" the mother, and "overt act" to kill in an effort to demonstrate that the terms, individually and taken together, are confusing and could encompass procedures undertaken during a D&E or induction. They state that "[d]uring the course of all D&Es, all of the products of conception will be drawn or expelled through the cervical os and 'outside the body' of the woman." Pls' TRO Mem. at 12. They also state that, "during the course of" a D&E or induction, several routine steps may cause fetal demise- such as rupturing the amniotic sac, dismembering part of the fetus, compressing or making an incision in the skull- but that "there is no way to know the precise cause or timing of fetal demise." *Id.* at 19; *see also id.* at 34 ("during the course of" a D&E or induction abortion, different steps may cause fetal demise "but not immediately").

What such assertions overlook is (i) the definition of partial birth abortion in the Act is structured and worded to encompass a specific procedure performed sequentially and after the fetal head or torso is already outside the body of the mother and (ii) the D&E method of abortion has been repeatedly characterized as an internal dismemberment procedure and readily distinguished from the D&X procedure on which Congress focused. Read as the statute is plainly written, and viewed in the light of established descriptions of D&E, plaintiffs' vagueness claim should be rejected.

First, a partial-birth abortion under the Act requires a specific time and place for the killing of the fetus- in the middle of "delivery" and outside the body of the mother. The Act narrowly and specifically defines a partial delivery as one in which the provider

> (A) deliberately and intentionally vaginally delivers a living fetus until, in

> the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and
>
> (B) performs the overt act, other than completion of delivery, that kills the partially delivered living fetus . . .

Act, § 3 (to be codified at 18 U.S.C. § 1531 (b)(1)(A), (B)) (emphasis added). Congressional findings in support of the Act likewise describe a partial-birth abortion as

> an abortion in which a physician deliberately and intentionally vaginally delivers a living, unborn child's body until either the entire baby's head is outside the body of the mother, or any part of the baby's trunk past the navel is outside the mother and only the head remains inside the womb, for the purpose of performing an overt act (usually the puncturing of the back of the child's skull and removing the baby's brains) that the person knows will kill the partially delivered infant, performs this act, and then completes delivery of the dead infant . . .

Act, § 2(1). The intentional- and sequential- nature of the partial-birth abortion procedure is apparent. First, the physician must deliberately and intentionally partially deliver a living fetus. Second, the delivery is then stopped mid-course. Third, before delivery is completed, the living fetus, which is now largely outside the mother, is then

killed by a separate overt act (usually the removal of cranial matter). Finally, the delivery of the fetus is completed. Moreover, the living fetus must be delivered to a certain anatomical extent outside the body of the mother before it is killed – either its head must be outside the body of the mother, or, in the breech position, the fetus must be removed to a precise anatomical point, the navel.

What plaintiffs have done is taken elements of the definition, such as "living fetus," "outside" the body, and "overt act" to kill and argued that, where these elements exist in other procedures, that method of abortion may be banned by the Act. The fact that, during the course of a D&E or induction, the "products of conception" are removed to a point "outside the mother," or some "overt act" is taken to kill a living fetus, or that the fetus may show signs of life thereafter outside the body, does not render D&E or induction a banned procedure. Under the Act, the specific act to kill the fetus must happen at a particular point and place in time: after the fetus is intentionally delivered outside the mother for the purpose of then inflicting a separate act to kill. The concern that a physician would not know the "precise time" of fetal demise during a D&E, or that a dismembered fetus has a heartbeat after a D&E, is irrelevant. The relevant question is whether a separate act to kill a was inflicted after it was removed from the mother to a specific anatomical point.

Beyond this, the D&E method of abortion has been repeatedly characterized by medical experts on both sides of the debate as an internal dismemberment procedure. Dr. Haskell, who authored the monograph that first alerted Congress and the American public to the use of the partial-birth abortion procedure, distinguished his procedure from "classic D&E in that it does not rely upon dismemberment to remove the fetus . . . . Rather, the surgeon grasps and removes a nearly intact fetus through

an adequately dilated cervix." HJC 7/9/02 at 127. Dr. Carhart testified in *Stenberg* that the D&E procedure requires the doctor to use instruments to grasp a portion (such as a foot or hand) and use the traction created by the opening between the uterus and vagina to dismember the fetus, tearing the grasped portion away from the remainder of the body. *Stenberg*, 530 U.S. at 925-26. Dr. Carhart further testified that, during a D&E, "dismemberment occurs between the traction of . . . my instrument and the counter-traction of the internal os of the cervix . . ." *Id.* At the conclusion of a D&E abortion, Dr. Carhart described the fetus as reduced to "a tray full of pieces." *Id.* at 959.

Indeed, the problem found by the Supreme Court with the definition of the procedure invalidated in *Stenberg* was that it could be construed to encompass vaginal dismemberment of limbs under the D&E procedure. The Nebraska statute held unconstitutional in *Stenberg* prohibited "deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, . . . " 530 U.S. at 938 (citing Neb. Rev. Stat. Ann. § 28-326(9)). The Supreme Court concluded that the Nebraska law prohibited D&E abortions because a "D&E will often involve a physician, pulling a 'substantial portion' of a still living fetus, say, an arm or leg, into the vagina prior to the death of the fetus." *Id.* at 939.

The Supreme Court's concerns over the language expressed in *Stenberg* are not implicated here. The language crafted by Congress no longer provides that the procedure is performed inter-vaginally, but on a living fetus that is outside the mother's body. Congress also replaces the language that a "substantial portion" of the fetus is pulled into the vaginal area, with language that the fetus is removed outside the body to at least a specific anatomic landmark – either the "entire fetal head" is outside the mother or, in the breech presentation, any

part of the fetal trunk past the navel. This language is unquestionably much more specific than the language in Stenberg.

For these reasons, various scenarios raised by plaintiffs in which a D&E abortion might fall under the language of the Act, such as because the cervix has prolapsed into alignment with the vaginal introitus, do not render the Act unconstitutionally vague. In light of the clearly structured definition in the Act, and the established description of the D&E procedure, plaintiffs' self-serving and untested affidavits cannot be credited at this initial stage. Unverified assertions about what could happen during a D&E or induction not only confuse the elements of the partial-birth abortion procedure, but miss the key overall point – the Act is intended to prohibit a procedure by which a living fetus is intentionally drawn partially outside the body of the mother for the purpose of killing it in the middle of delivery. Also, "[t]hat there may be marginal cases in which it is difficult to determine the side of the line on which a particular fact situation falls is no sufficient reason to hold the language too ambiguous to define a criminal offense." *Petrillo*, 332 U.S. at 7 (citation omitted). When it is abundantly clear from eight years of legislative history containing substantial medical evidence that Congress intended to prohibit a specific procedure in which a partially-born fetus is killed in the middle of delivery, the existence of some borderline situations does not rise to a level of vagueness that justifies invalidating the Act. *See United States v. Harriss*, 347 U.S. 612, 618 (1954) ("[I]f the general class of offenses to which the statute is directed is plainly within its terms, the statute will not be struck down as vague even though marginal cases could be put where doubts might arise.") (citing *Petrillo*, 332 U.S. at 7).

> The Constitution has erected procedural safeguards to protect against conviction for crime except for violation of laws

> which have clearly defined conduct thereafter to be punished; but the Constitution does not require impossible standards. The language here challenged conveys sufficiently definite warning as to the proscribed conduct when measured by common understanding and practices. The Constitution requires no more.

Petrillo, 332 U.S. at 7.

Finally, plaintiffs' critique the Act for not containing a viability line, not demarcating specific abortion procedures that are not affected, not including the word "intact," or not describing procedures regarding the suctioning of skull contents. *See* Pls' TRO Mem. at 32 n.31. These points are easily addressed. Congress' decision not to legislate these distinctions does not render the Act it did write impermissibly vague. Congress could justifiably find that the precise point of viability may change, and that the destruction of a late term, living fetus outside the womb is just as objectionable, even if the fetus quite near, but not yet past, viability. Also, utilizing the term "intact" in the Act would presents an obvious loophole that would allow the virtually identical procedure to occur where a single fetal toe had been dismembered. Lastly, defining the specific overt act to kill as solely suctioning of brain content again would permit the identical procedure – the killing of a living fetus outside the body and inches from a complete birth – to proceed through some other means of killing. The point of the legislation was to prohibit the destruction of a living fetus inches from an autonomous existence. That Congress chose not to legislate the limitations plaintiffs' cite in no way renders the Act unconstitutionally vague.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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03 Civ. 8695 (RCC)

NATIONAL ABORTION FEDERATION; MARK I. EVANS, M.D.; CAROLYN WESTHOFF, M.D., MSC; CASSING HAMMOND, M.D.; MARK HELLER, M.D.; TIMOTHY R.B. JOHNSON, M.D.; STEPHEN CHASEN, M.D.; GERSON WEISS, M.D., ON BEHALF OF THEMSELVES AND THEIR PATIENTS,

Plaintiffs,

v.

JOHN ASHCROFT, IN HIS OFFICIAL CAPACITY AS ATTORNEY GENERAL OF THE U.S., ALONG WITH HIS OFFICERS, AGENTS, SERVANT, EMPLOYEES, AND SUCCESSORS IN OFFICE,

Defendants.

New York, N.Y.
Before:
HON. RICHARD CONWAY CASEY
District Judge

TRIAL TRANSCRIPT EXCERPTS

Cassing Hammond, M.D. (619:5 – 620:9)

Q. Doctor, I am referring back to the first topic you raised as opposed to the second. The second one was your opinion that the ban is broad and vague. The first was that you, I believe, stated that the findings contained different information than the definition that is contained in the Act's ban. Am I understanding your testimony correctly?

A. You are.

Q. Can you explain what you mean by that.

A. There are several things that are discussed in the findings that aren't actually included in the ban itself. If you would like, I can identify some of those.

Q. That would be great.

A. If you go back to the beginning of the findings section -- again. this is section 2, findings -- let me look here and make sure I am referring to the right place.

THE COURT: Are you saying, Doctor, that some of these things you are talking about that are effects are not in the ban? Would you expect the effects to be in the ban? I know you are not a lawyer, but isn't it rather obvious?

THE WITNESS: No, I don't think I am talking about effects, your Honor.

THE COURT: You have been through all of those and you have noted those you agree with and disagree with,

but I don't know that your statement makes any sense to me.

THE WITNESS: There is some language that is used to define or describe partial-birth abortion in the findings that doesn't appear in the ban at all. So I don't know if what is banned necessitates that I do those actions listed in the findings or not. They are different. They describe partial-birth abortion in different ways.

Carolyn Westhoff, M.D., MSc. (845:2 – 846:1)

Q. Dr. Westhoff, without enumerating them, have you perceived any differences between language that describes a certain abortion procedures in the findings of the statute and language that appears in the text of the ban in Section 1531(b) (l)?

A. Yes. The ban is more general than the findings.

Q. Mindful of the Court's ruling I'm not going to take you through those differences but instead will ask you this: What impact, if any between those differences, between the text of the ban in Section 1531(b) (1) and the text in the findings, have on your ability as a physician to determine what conduct is prohibited by the ban?

A. The language –

THE COURT: Doesn't your question presume a fact that hasn't been established?

MR. HUT: I said what difficulty if any, your Honor. What impact, if any -- at least I certainly intended to.

THE COURT: All right.
Can you answer that question?

THE WITNESS: Reading the ban, the language is more general and brief than in the findings. And it appears that it could apply to a broader range of D&Es that I perform including D&Es that involve dismemberment because it doesn't say anything about intact. And, therefore, it's really difficult for me to tell when I am actually doing a case exactly whether I would be violating the ban.

Charles Lockwood, M.D. (1877:7 – 1878:18)

Q. In December you found distressing the Act's imposition of penalties on doctors, right?

A. Still do.

Q. You think that the imposition of criminal penalties unravels the physician's social contract with his or her patients, right?

A. Correct.

Q. Because part of that contract is a right of patients to expect doctors to do their very best for them, right?

A. Correct.

Q. You also thought in mid December 2003 that it was entirely unconscionable for Congress to incur civil suits, right?

A. Very much so.

Q. And you still do, right?

A. Very much so.

Q. In December, before you spoke with counsel for the government, you believed that the Act's language was so imprecise that it just doesn't prohibit intact D&E is but also threatens all abortions, right?

A. Correct.

Q. So when you first read the Act as a practicing physician without conferring with government lawyers, you believed it was written in a way that threatened all abortions, right?

A. I wrote what I wrote.

Q. And you did believe that, right?

A. Correct. To be fair to all sides, I had reviewed the expert reports of your plaintiffs, and that may have added to my sense of urgency and concern.

Q. In fact, in your opinion, the wording of the Act is such that you can certainly understand why the plaintiffs' experts opined as they did concerning the Act's threat, right?

A. Correct.

Q. You still agree, don't you, Dr. Lockwood, that if the Act is not interpreted the way you believe appropriate, it is not only vague but worse, right?

A. If it is interpreted in a way that leads to a lack of access to pregnancy terminations, that would be a problem.

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Supreme Court of the United States

ALBERTO R. GONZALES, ATTORNEY GENERAL,
Petitioner,

v.

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF *AMICI CURIAE* AMERICAN MEDICAL WOMEN'S ASSOCIATION, AMERICAN PUBLIC HEALTH ASSOCIATION, ET AL. IN SUPPORT OF RESPONDENTS

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This brief is filed on behalf of the following seven organizations and forty-one individuals:

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American Public Health Association
Medical Students for Choice
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INTEREST OF *AMICI CURIAE*

Amici curiae are medical and public health organizations and institutions, as well as individual physicians and academicians who oppose the Partial Birth Abortion Act of 2003 because it jeopardizes women's health by criminalizing safe and effective abortion procedures, and further restricts the study and advancement of such procedures. *Amici* and their members believe that their insight and hands-on experience with the methods by which surgical procedures evolve and surgeons determine whether procedures are safe and beneficial for their patients will assist the Court in construing Congress's findings and the impact of the statute in this case.

Amici include 41 individual physicians, surgeons, medical ethicists, medical historians and the following entities: **American Medical Women's Association** (national organization of 10,000 women physicians, surgeons, and physicians-in-training dedicated to promoting women's health); **American Public Health Association** (oldest, largest, and most diverse organization of public health professionals in the world; has a long standing commitment to reproductive rights and reproductive choice); **Medical Students for Choice** (organization of nearly 10,000 medical students and residents seeking comprehensive medical education including abortion training); **National Family Planning & Reproductive Health Association** (represents clinicians, administrators, researchers, educators, advocates and providers in the family planning field who provide reproductive health care services at nearly 4,500 clinics to more than 5 million women annually); **New York Obstetrical Society** (a 140-year-old regional organization of obstetrician-gynecologists and gynecological surgeons who are leaders in the field of women's health care); **Physicians for Reproductive Choice** (national organization of physicians of various specialties that exists to promote,

educate and advocate about the importance of comprehensive reproductive healthcare and to ensure that all people have the knowledge, access to quality services and freedom to make their own reproductive health decisions); **University of Chicago Hospitals, Department of Obstetrics and Gynecology** (physicians and surgeons, including maternal-fetal medicine specialists, practicing at a top ranked hospital, affiliated with a leading academic institution).[1]

SUMMARY OF ARGUMENT

Through the Partial Birth Abortion Ban Act of 2003 (the "Act"), Pub. L. No. 108-105, 117 Stat. 1201 (codified at 18 U.S.C. § 1531), Congress has attempted to prohibit some of the most common and safest methods of abortion in the second trimester, without providing an exception to preserve a woman's health. Congress attempted to justify this attack on women's health by "finding" that so-called "partial birth abortion" is never medically necessary because "[t]here is no credible medical evidence that partial-birth abortions are safe or are safer than other abortion procedures." *Id.* § 2(14)(B), 117 Stat. at 1204.[2] Congress based that conclusion in substantial part on the fact that no controlled or comparative studies or peer-reviewed articles had demonstrated the safety and efficacy of such procedures. See *id.*; but see Br. *Amicus Curiae*, American College of Obstetricians and Gynecologists 17-18 (collecting peer-reviewed literature on intact D&E).

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[1] Letters of consent have been filed with the Clerk. Pursuant to Rule 37.6, *amici* state that no counsel for a party authored any part of this brief, and no person or entity other than *amici* and their counsel made a monetary contribution to the preparation or submission of this brief.

[2] "[P]artial birth abortion" is not a medical term and does not refer to any procedure. But, since the Government sometimes asserts that it is the same as surgical abortions in which the physician succeeds in removing the fetus intact or largely intact (referred to herein as the intact variation of dilation and evacuation abortion, or "intact D&E"), *amici* address the safety and evolution of intact D&E procedures.

Congress's conclusion is built on a false premise. Controlled or comparative studies are common in the pharmaceutical context, and are certainly a valuable method of evaluating safety and efficacy in medicine in general. However, they have never been the method surgeons have used to determine whether new surgical procedures, or variations on familiar procedures, are safe to employ and provide health benefits to their patients. Surgery, by its nature, does not fit the randomized control trial ("RCT") paradigm. When a new technique is first developed, there is simply no way to create a sufficient number of "trials" to conduct a controlled study. Even after a new surgical technique has reached a level of acceptance in the surgical community, circumstances often continue to preclude such evaluation. However, despite substantial impediments to controlled studies, the level of knowledge and skill in the surgical profession has exploded in the past century because the surgical community has developed a field-specific approach: it engages in widespread communication regarding common problems, theoretical approaches and ultimately practical solutions. When a surgeon finds a technique that represents an improvement over prior techniques, he or she records the results and shares them with others, who then begin to perform the new technique and share their experience.

This is the way numerous now familiar procedures were introduced and evaluated when they were new and untested. The safety and health benefits of intact D&E have been demonstrated in the same manner. Accordingly, as each of the lower courts to have addressed Congress's findings has concluded, "credible medical evidence" does, in fact, exist to show that intact D&E is not only safe and effective, but it is often safer than alternative methods of terminating pregnancy in the second trimester.

When viewed in light of these standards, this Court's longstanding abortion jurisprudence renders the Act

unconstitutional. The Act places women's health in jeopardy. This Court has *never* held that *any* government interest is strong enough to outweigh the combined interest of the state and the woman in her health.

Neither can the Act be saved by the availability of other abortion procedures that the Government claims are "safe enough." This artificial standard of safety is foreign to surgical practice. Surgeons seek to maximize the safety and health benefits for each patient for whom they care. They do not merely conclude that a procedure is "safe enough" and then decline to take further steps or make additional innovations to advance their patients' health interests. Nor would any patient want his or her physician to follow such a minimalist approach. An ongoing effort to reduce patient risk is a paramount obligation for surgeons—an obligation that cannot, consistent with this Court's precedent, be undermined where, as here, it would increase risks to women's health.

ARGUMENT

I. INTACT D&E HAS EVOLVED IN A MANNER CONSISTENT WITH OTHER SURGICAL TECHNIQUES AND ITS SAFETY AND HEALTH BENEFITS HAVE BEEN EQUALLY WELL DEMONSTRATED.

A. Contrary To Congress's Findings, Surgical Techniques Develop Without Reliance On Controlled Trials.

The development of new surgical techniques responds to surgery's unique demands and differs markedly from the way new therapies are developed in other areas of medicine. Initial development of surgical techniques and procedures rarely, if ever, depends on prospective research. Instead it evolves based on practitioner experience, observation and innovation. Surgical advancement commonly occurs when, in the course of performing an existing procedure, a physician

conceives of a way to improve the procedure through modification, tries the new method, and if successful, continues to employ it. See, *e.g.*, *Gonzales* v. *Carhart*, No. 05-380 (U.S.), Pet. App. 397a;[3] Sherwin B. Nuland, *Doctors: The Biography of Medicine* 410 (1988) (describing development of radical mastectomy; the procedure combined "the best features of all previous approaches" and took them one step further).

After a surgeon finds that his or her innovation appears to benefit patients, the surgeon informs others through a variety of means, ranging from formal conference presentations to more informal training sessions for institutional colleagues or communication with other physicians. Other surgeons then attempt the refined procedure, relaying to others word of their experiences with the technique and its safety and efficacy. Through these innovations and adaptations, the procedure evolves to the point that it is either discarded, or surgeons gain sufficient confidence to put it into regular practice and to determine whether it is the best and safest approach for a particular patient. See *e.g.*, Nuland, *supra*, at 410, 448-49 (discussing the spread of knowledge concerning various surgical procedures); *Carhart* Pet. App. 468a (citing William H. Frist & D. Craig Miller, *Repair of Ascending Aortic Aneurisms and Dissections*, 1 J. Cardiac Surg. 33, 45-46 (1986) (describing now-Senator Frist's view that surgeons rely on clinical experience to determine whether a surgical technique is appropriate)). Surgeons who, based on skill and experience, believe that a new surgical approach provides advantages for particular patients will not wait for the results of a large scale controlled study before putting the new approach into practice. *Carhart* Pet. App. 341a.

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[3] Hereafter, *amici* refer to the Petitioner's Appendix in *Gonzales* v. *Carhart* as "*Carhart* Pet. App." and the appendices in *Gonzales* v. *PPFA* as "App." and "Pet. App."

Consistent with this approach to surgical innovation, the first published articles about a surgical innovation are likely to be retrospective and observational. *Id.* For example, a physician might publish outcomes of a particular procedure for one or more patients in a case study or series. In this situation, the physician has not treated patients in conformance with a predetermined study design. Instead, he or she has exercised his or her best clinical judgment at the time of treatment, carefully observed the outcomes, and reported the experience for the benefit of other experts in the field. The case study or series is a common way of sharing early individual experience, especially in the surgical community. Robin S. McLeod, *Issues in Surgical Randomized Controlled Trials*, 23 World J. Surg. 1210, 1213 (1999); Eric K. Fung, et al., *Randomized Controlled Trials for Evaluating Surgical Questions*, 128 Arch. Otolaryagol. Head Neck Surg. 631, 631 (2002); Pet. App. 143a. After treating a larger number of patients with a new surgical approach, a physician might publish a retrospective cohort study based on chart review. This type of study allows the researcher to compare and evaluate outcomes for two groups ("cohorts") of patients based on information contained in their medical charts. Pet. App. 109a.

Only much later—and only if an adequate sample size exists and medical ethics permit—can the modification be subjected to a prospective controlled trial.[4] See Claus Bartels et al., *Cardiopulmonary Bypass: Evidence or Experience Based?*, 124 J. Thorac. Cardiovasc. Surg. 20, 24-25 (2002). In prospective RCT research, patients are randomly assigned to either a group which will receive new treatment, or a

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[4] It would be inappropriate to begin a controlled trial too soon after the introduction of a new surgical procedure. Among other reasons, the new procedure must be in existence long enough to be sufficiently familiar to surgeons so they may enroll an adequate number of participants, and the surgeons must be sufficiently experienced that operator variation can be controlled enough to satisfy scientific norms. McLeod, *supra*, at 1211.

control group which will receive an existing treatment. Fung et al., *supra*, at 631. In such trials, study designers attempt to control as many extrinsic factors as possible, removing confounding variables so that differences between the groups can be attributed to the new treatment and not patient- or physician-specific factors. McLeod, *supra*, at 1210; Fung, *supra*. RCTs, when possible, are often considered the most reliable form of medical research. McLeod, *supra*, at 1210; Fung, *supra*, at 631; but see Tom L. Beauchamp & James F. Childress, *Principles of Biomedical Ethics* 327 (5th ed. 2001) ("RCTs should not become indispensable rituals or necessary canons of valid research."); Kjell Benson et al., *A Comparison of Observational Studies and Randomized, Controlled Trials*, 342 New Eng. J. Med. 1878, 1883 (2000) (estimates of the effects of treatment in observational studies and randomized controlled trials were similar). Despite the acknowledged benefits of having RCT data, it is not always practical or even possible to conduct such trials, particularly for surgical advancement. Bartels, *supra*, at 24-25; Fung, *supra*, at 631-32; Michael J. Solomon & Robin S. McLeod, *Surgery and the Randomised Controlled Trial: Past, Present and Future*, 169 Med. J. Australia 380, 381-82 (1998).

The first barrier is surgeon enrollment. In some cases, by the time an adaptation has evolved to the point of being eligible for systematized study, it has already been embraced by surgeons, who cannot ethically participate in RCT study unless they believe there is uncertainty as to which approach is the most effective.[5] Albert R. Jonsen et al., *Clinical Ethics* 204 (6th ed. 2006); Bernard Lo, *Resolving Ethical Dilemmas: A Guide for Clinicians* 177 (3d ed. 2005). Otherwise, the

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[5] This principle of genuine uncertainty is known as "equipoise." Clinical research ethics require that there be equipoise on the part of the individual clinical investigator or clinical equipoise about the preferred treatment within the expert medical community. Benjamin Freedman, *Equipoise and the Ethics of Clinical Research*, 317 New Eng. J. Med. 141, 141 (1987).

surgeon is ethically required to use what he or she believes is the safest and most effective technique for the particular patient. Lo, *supra*, at 177; Beauchamp & Childress, *supra*, at 327.

When there is sufficient doubt so that an RCT would be ethical, the nature of surgery nevertheless often renders the goal of randomization unattainable.[6] If, as is often the case, patients already have a preference for a particular procedure or technique, patient recruitment becomes an obstacle to randomized study. Fung, *supra*, at 632; Solomon & McLeod, *supra*, at 381.[7] Patient preference has frustrated efforts to conduct RCTs in a number of surgical contexts. See, *e.g.*, D. A. Grimes et al., *Mifepristone and misoprostal versus dilation and evacuation for mid-trimester abortion: a pilot randomized controlled trial*, 111 B. J. Obstet. Gynecol. 148, 148 (2004) (unable to conduct RCT because of vast patient

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[6] In attempting to compare intact D&E to a dismemberment approach randomization is nearly impossible. As is discussed below, a physician does not know when beginning a D&E whether the fetus will present intact, or largely intact, or whether it will be necessary to dismember the fetus—even where the physician makes every effort to remove the fetus as intact as possible. Pet. App. 142a. Thus, a comparative study would be possible only by dividing procedures into two groups *after* the surgery—one more intact and one more dismembered—and comparing the complication types and rates as well as patient benefits. This type of retrospective cohort study is precisely the approach taken in the first study to attempt to compare dismemberment and intact variations or D&E. *See* Stephen T. Chasen et al., *Dilation and Evacuation at ≥ 20 Weeks: Comparison of Operative Techniques*, 190 Am. J. Obstet. & Gynec. 1180 (2004) (App. 1055-70) (hereinafter "Chasen, *D&E*").

[7] Randomization is also unappealing to surgeons who believe that it requires the surgeon to acknowledge ambivalence as to which treatment approach is safest and thus compromises apparent authority and expertise. R. Lefering & E. Neugebauer, *Problems of Randomized Controlled Trials (RCT) in Surgery* (1997), *available at* http://www.symposion.com/nrccs/lefering.htm; *see also* Fung, *supra*, at 632. In turn, the hesitancy of surgeons to participate and solicit their patients for studies exacerbates the problem of patient recruitment. Lefering & Neugebauer, *supra*.

preference for D&E over induction abortion); McLeod, *supra*, at 1212 (unable to conduct trial comparing mastectomy to lumpectomy).

Even when surgical studies can be randomized, they are hard to standardize and control. For example, variations in skill and training among surgeons make standardization difficult to achieve. If different surgeons operate on different patients, it may be impossible to determine whether the success of a procedure is attributable to the procedure or to the surgeon's skill in executing it. David S. Jones, *Visions of Cure: Visualization, Clinical Trials, and Controversies in Cardiac Therapies, 1968-1998*, 91 Isis 504, 523 (2002); Fung, *supra*, at 632-33; McLeod, *supra*, at 1210. Having a single surgeon conduct every surgery in a study could theoretically solve the standardization problem. Lefering & Neugebauer, *supra*. However, no surgeon can conduct a procedure in the exact same way every time. A surgeon must respond to patient- and procedure-specific circumstances that arise during the surgery, making it impossible to standardize multiple procedures. McLeod, *supra*, at 1210; see Joel E. Frader & Donna A. Caniano, *Research and Innovation in Surgery, in Surgical Ethics* 216, 216 (Laurence B. McCullough et al. eds., 1998) ("Even on the same day, with similar patients, a single surgeon may perform 'the same' procedure somewhat differently, due to anatomic or physiologic differences among patients or for other reasons.").[8]

These barriers are especially problematic when the surgical techniques being compared have low complication and high success rates, as is the case with all variations of D&E. Pet. App. 141a. In such cases, a study can only produce

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[8] Furthermore, the more a surgeon performs a technique or procedure, the more effective he or she becomes, thereby reducing the complication rates on the procedure over time—again undercutting standardization. Fung, *supra*, at 632-33.

statistically significant results if it includes a high volume of participants. The barriers to participation discussed above can thus render RCTs impossible.

As a result, surgeons frequently rely on other methods of attaining confidence in a new or modified surgical procedure. Congress's artificial notion that RCTs are necessary to demonstrate the safety and efficacy of a particular surgical procedure is inaccurate and flatly inconsistent with the standards to which surgical professionals currently adhere. As illustrated below, the development of intact D&E is consistent with the standards applied to other surgical innovations. If Congress had banned surgical procedures at this stage of development on an RCT rationale, the nation would have been deprived of the benefits of some of the most important surgical advancements in the past century.

One of the greatest surgical developments of the twentieth century is the widespread use of minimally invasive laparoscopic techniques. Because the laparoscopic incision is much smaller than the incision in a traditional "open" procedure, patients have less pain, shorter hospital stays, briefer recovery periods and reduced scarring. See, *e.g.*, U. Giger et al., *Laparoscopic Cholecystectomy in Acute Cholecystitis: Indication, Technique, Risk and Outcome*, 390 Langenbecks Arch. Surg. 373, 373 (2005). As a result, even in the absence of controlled trials demonstrating relative effectiveness and safety, laparoscopic surgery became the method of choice for surgeons and patients almost as soon as its use became an option.

Laparoscopic surgery requires only small incisions through which the surgeon passes surgical instruments and removes tissue. Instead of direct visualization, the surgeon observes the target of the surgery through a small camera with the image projected onto a screen in the operating room. Laparoscopic surgery evolved from the use of an endoscope to visualize the interior of the human body for diagnostic purposes. G.S. Litynski & V. Paolucci, *Origin of Laparo-*

scopy: Coincidence of Surgical Interdisciplinary Thought?, 22 World J. Surg. 899, 900-01 (1998). Early endoscopes—first just small mirrors with illumination—were inserted into the abdomen to permit visualization of internal organs without large incisions. See *id.* Surgeons later adapted the technology for surgical use by inserting specialized surgical instruments through other small incisions and visualizing the operating area through the endoscope.

One application of this surgical innovation is the laparoscopic cholecystectomy, used to remove a diseased gall bladder for treatment of gallstones. The traditional method of cholecystectomy, the "open" method (in which the surgeon makes an incision large enough to visualize and touch the gall bladder and the interior of the abdomen), was first performed in 1882, and for more than 100 years was the "gold standard" for treatment of gall bladder disease. See Giger, *supra*, at 373; Thomas R. Gadacz et al., *Traditional Versus Laparoscopic Cholecystectomy*, 161 Am. J. Surg. 336, 337 (1991). In the mid-1980s, a German surgeon performed the first reported laparoscopic cholecystectomy. Giger, *supra*, at 373; see also J. Barry McKernan, *Origin of Laparoscopic Cholecystectomy in the USA: Personal Experience*, 23 World J. Surg. 332, 333 (1999). Word of this innovation spread through conversations and at conferences. See Thomas L. Dent et al., *Minimal Access General Surgery: the Dawn of a New Era*, 161 Am. J. Surg. 323, 323 (1991) (videotape of procedure shown at conference in 1989).

After anecdotal results were presented to surgeons, patients became aware of its benefits through reports in the lay press. Lefering & Neugebauer, *supra*. Patients began insisting that their cholecystectomies be performed laparoscopically. Within six years of the first laparoscopic cholecystectomy, and despite the absence of formal clinical trials establishing safety and effectiveness, the method became widely available in both the United States and Europe. C. Randle Voyles, *A*

Practical Approach to Laparoscopic Cholecystectomy, 161 Am. J. Surg. 365, 365 (1991).

In fact, researchers had difficulty recruiting patients for controlled trials testing laparoscopic cholecystectomy against the open method because "initial reports and articles in the lay press" suggested that the laparoscopic method was far superior to the open method. Lefering & Neugebauer. *supra.* In 1992, the National Institutes of Health concluded that "laparoscopic cholecystectomy provides a safe and effective treatment" for removal of gall bladder for treatment of gall stones, while acknowledging that "well-controlled studies [of its comparative benefits] are unavailable, and there is little prospect that such studies will be done." *Gallstones and Laparoscopic Cholecystectomy*, NIH Consensus Statement 10(3) (Sept. 16, 1992), *available at* http://consensus.nih.gov/1992/1992GallstonesLaparoscopy090html.htm.

Laparoscopic surgery is but one example of this recurring evolutionary phenomenon. Other procedures, including radical mastectomy, the B-Lynch suture, coronary artery bypass grafting ("CABG"), angioplasty, and coronary pulmonary bypass similarly evolved through surgical practice. See, *e.g.*, Jones, *supra*, at 513-16 (discussing evolution of CABG, which came into practice in 1967, and noting that despite lack of RCTs, 100,000 CABGs had been completed by 1974); see also *id.* at 538-39 (angioplasty was first performed in 1977, and the first comparative trials were not published until 1992).

B. The Evolution Of Intact D&E Comports With The Standards For Safety And Efficacy In Surgical Advancement.

The intact approach to D&E came into existence in the same manner as these other surgical procedures: surgeons modified an existing technique to reduce risks, discussed their successful surgeries with colleagues, and slowly began to present the new variation formally at meetings and in journal

publications. As a result, intact D&E has become accepted as safe for terminating second trimester pregnancy, and is widely endorsed by physicians, including those practicing at some of the most prestigious teaching institutions in the country. Pet. App. 205a. These physicians believe, based on extensive experience, that removing the fetus as intact as possible is the safest approach for all patients, and that doing so is particularly important for certain patients in already compromised medical conditions. *Carhart* Pet. App. 497-500a; Pet. App. 143-44a, 147a.

The most appropriate abortion procedure for a particular patient is based on a number of factors, including gestational age. In a vacuum or suction curettage—the most common method in the first trimester—the cervix is dilated and a manual or electric suction tool is used to evacuate the uterus. Phillip G. Stubblefield et al., *Methods for Induced Abortion*, 104 Obstet. & Gynec. 174, 175-76 (2004). Because of the relatively small size of an embryo or first-trimester fetus, this tool alone typically can remove the fetus and all products of conception. But as pregnancy progresses, the small tools and limited dilation achieved during vacuum aspiration become inadequate to empty the uterus safely.

As a result, in the early 1970s, abortion after 12-weeks gestation generally took place in a hospital by labor induction. *Id.* at 179. However, with the advent of safe methods for greater cervical dilation at this later stage of pregnancy, it became possible to perform surgical terminations (D&E) throughout the second trimester. W. Martin Haskell et al., *Surgical Abortion After the First Trimester, in A Clinician's Guide to Medical & Surgical Abortion* 123 (Maureen Paul et al. eds., 1999) (hereinafter "*Clinician's Guide*"); see also Pet. App. 65-66a; *Carhart* Pet. App. 399a. Compared to labor induction, D&E offered abortion patients a significantly shorter procedure, with less pain and discomfort, that could be provided on an out-patient basis. Pet. App. 142a. While D&E required greater skill on the part of the physician,

because of its advantages, D&E quickly became recognized as the safest method of terminating pregnancy in the second trimester. *Clinician's Guide*, *supra*, at 125; see also Chasen, *D&E* at 1180 (App. 1057).

In D&E, after the cervix is dilated, the physician uses grasping tools such as a forceps to remove the fetus and the placenta from the uterus. Stubblefield et al., *supra*, at 179. In many cases, the fetus disarticulates as it is grasped and drawn through the cervix. Pet. App. 60a. Though extremely safe, D&E with disarticulation (or dismemberment) carries potential risks, which although rare, can be devastating.[9] Specifically, the approach involves repeated passes of instruments through the cervix into the uterus and removal of bony fragments, both of which create a risk of perforation or laceration of the highly vascularized uterus and/or cervix, some of the most feared complications of D&E. Chasen, *D&E* at 1183 (App. 1063-64); Pet. App. 144a; see also *Nat'l Abortion Fed'n* v. *Ashcroft*, 330 F. Supp. 2d 436, 471 (S.D.N.Y. 2004), *aff'd in part sub nom.* 437 F.3d 278 (2d Cir. 2006).

As dilation techniques evolved, physicians began to seek wider cervical dilation to facilitate evacuation, which increases the chances of removing the fetus as intact as possible. Stubblefield, *supra*, at 179; Chasen, *D&E* at 1183 (App. 1063); *Clinician's Guide*, *supra*, at 136. Intact removal obviates the need for repeated passes with instruments and removal of sharp bony fragments. *Carhart* Pet. App. 497-98a; Pet. App. 144a. It gives the surgeon certainty that all

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[9] In medicine, the term "risk" encompasses both probability and gravity. The first study comparing intact D&E to D&E with dismemberment, showed general complication rates were the same, but all serious complications were in the dismemberment group, Chasen, *D&E* at 1183 (App. 1063). This evidence of intact D&E's safety was particularly significant since the intact procedures occurred later in gestation, so researchers had expected to see more complications from that group. Pet. App. 117a; *Carhart* Pet. App. 359a.

fetal tissue has been removed, reducing the risk of infection, and offers the potential for shorter operating times, and thus less time under anesthesia. *Carhart* Pet. App. 497-98a; Pet. App. 144a.[10]

While physicians have long known of the benefits of minimizing instrumentation, the first presentation that suggested techniques to maximize the chance of intact removal took place in 1992. It was delivered by Dr. Martin Haskell at a conference of the National Abortion Federation ("NAF"). Dr. Haskell described both dilation techniques and intra-operative techniques used to maximize the possibility of intact removal. See Martin Haskell, *Dilation and Extraction for Late Second Trimester Abortion* 127-28, Presented at Nat'l Abortion Fed'n, Second Trimester Abortion: From Every Angle Seminar (Sept. 13, 1992). Three years later, another physician presented a retrospective observational paper regarding his experience performing an intact variation of D&E. See James T. McMahon, *Intact D&E: The First Decade* at 19, Presentation at NAF Conference (Apr. 2, 1995); see also *Clinician's Guide*, *supra*, at 136.

Following these presentations, other physicians took steps to incorporate aspects of what these physicians called

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[10] Intact D&E also offers psychological benefits and the possibility of increasing a woman's success in carrying future pregnancies to term. Many abortions that take place later in the second trimester are of pregnancies that are very much wanted, but which the patient elects to terminate after learning that she is suffering from a medical condition inconsistent with carrying the pregnancy to term, or that her fetus suffers from an anomaly making sustained survival outside the uterus unlikely. App. 105-08, 208-11, 257-60, 391, 420. These patients often wish to see and hold the fetus, and mourn its death. Pet. App. 105a, 142-43a; *Clinician's Guide*, *supra*, at 136. Moreover, an intact specimen allows for a more complete and sophisticated evaluation of the anomalies with which the fetus was afflicted. Pet. App. 105a; App. 924-25. For patients hoping to later carry a healthy pregnancy to term, information obtained from such an evaluation can be critical to reducing the risk of future pregnancy problems. App. 130-31, 501-02, 924-25.

"dilation and extraction" or "intact D&E" into their own practices. While some physicians adopted an approach similar to that presented, others adapted variations more consistent with their own techniques and circumstances and those techniques continued to evolve through informal communication among practitioners. Pet. App. 67-68a. As this evolution continued, intact removal began to be taught at medical schools, Pet. App. 205a.; *Carhart* Pet. App. 473a, discussed in medical literature, see, *e.g.*, *Clinician's Guide*, *supra*, at 136-37; Stubblefield, *supra*, at 179 and endorsed by leading medical organizations. See, *e.g.*, ACOG Statement of Policy (Jan. 1997, *reaff'd*, Sept. 2000, *reaff'd*, July 2004).

In 2004, Dr. Stephen Chasen, Director of High Risk Obstetrics at New York Presbyterian-New York Weill Cornell Medical Center, and his colleagues published the results of a retrospective case review of patients who underwent surgical abortion at 20 weeks or later in pregnancy at Weill-Cornell Medical Center from 1996-2003. See Chasen, *D&E* at 1180 (App. 1055-70). This study compared outcomes for two cohorts: 1) those whose terminations were achieved largely intact, as defined in the study, and 2) those whose terminations were through dismemberment. *Id.* (App. 1059). It concluded that an intact variation of D&E was as safe as D&E with dismemberment, see *id.* at 1180 (App. 1059), and possibly safer. Pet. App. 117a; *Carhart* Pet. App. 359a; see also Chasen, *D&E* at 1182-83 (App. 1062-63). Dr. Chasen and his colleagues subsequently published a retrospective analysis of the risks of subsequent pre-term birth for the patients in these two cohorts. See Stephen T. Chasen et al., *Obstetric Outcomes After Surgical Abortion at ≥ 20 Weeks' Gestation*, 193 Am. J. Obstet. Gynec. 1161 (2005). Dr. Chasen has presented his study results at conferences, thus furthering the academic discussions about the safety and successes of the variations of D&E. See, *e.g.*, Stephen T. Chasen, *Surgical Abortion in the Second Trimester*,

Presentation at NAF Risk Management Conference (Oct. 2004).

This level of study—presentations at conferences, discussions among colleagues and publication of the retrospective case reviews—is consistent with the way surgical advancement has been evaluated historically. As Government expert, Dr. Watson Bowes, testified, the Chasen study is an appropriate and important first step in studying this variation of D&E. App. 577. Moreover, as with other surgical procedures, the absence of prospective controlled trials has proved immaterial to the conclusions drawn by learned surgeons that intact D&E carries with it significant health advantages. Any desire to conduct prospective, controlled trials of intact D&E would be frustrated by all of the challenges of surgical research in general, see *supra* at 6-10, as well as procedure-specific obstacles that make such study a near impossibility. See generally App. 384-89 (discussing the infeasibility of prospective controlled studies of second trimester abortion methods). As noted, even when trying to remove the fetus as intact as possible, physicians cannot know at the beginning of a D&E procedure whether the fetus will present intact or largely intact, or whether it will be necessary to dismember. Pet. App. 142a. As a result, patients cannot be prospectively randomized, and only a retrospective comparative study, like Dr. Chasen's, is even possible. See Chasen, *D&E* at 1180 (App. 1055-70).

In addition, because complication rates for D&E overall are very low, a study comparing relative complication rates for dismemberment and intact variations would need to include a great number of patients in order to find a statistically significant difference. App. 385-87 (recognizing that thousands of women would have to participate to reach statistical significance). Given that the universe of patients seeking pregnancy termination at the stage of gestation when intact removal may be successful on a relatively regular basis is very small, see *Abortion Surveillance—United States 2002*,

54 *Morbidity & Mortality Weekly Report* (Center for Disease Control & Prevention), Nov. 25, 2005, at 21 tbl.6, reaching a statistically significant result would be nearly impossible.

Furthermore, as discussed above, recruitment into prospective controlled surgical studies presents a particular challenge, as both patients and surgeons are hesitant to limit their surgical choices based on the parameters of a study. Many physicians believe that it is always safer to remove the fetus as intact as possible. Accordingly, it would be enormously difficult to recruit them into a study in which they agreed to attempt to dismember the fetus—something they believe to be less safe for their patients. See *supra* note 5 (discussing principle of individual and clinical equipoise).

The Act would prevent research of the relative safety of second trimester abortion options and would restrict physicians from attempting additional modifications aimed at further reducing complication rates and increasing safety. While infrequent, the serious complications that intact D&E can help to prevent can be catastrophic when they occur. Prohibiting intact D&E would deprive women of the best medical judgment in the field and of the significant health benefits the medical profession has recognized are associated with reducing these risks.

II. THE HEALTH BENEFITS OF INTACT D&E MANDATE THAT IT BE CONSTITUTIONALLY PROTECTED.

As demonstrated above, Congress has attempted to justify a ban on safe abortion procedures by imposing an artificial and unrealistic standard for judging safety that the surgical community does not impose on itself, and that as a practical matter can never be the sole standard by which surgeons judge the safety and health benefits of new procedures. This Court has long recognized that the constitutionality of regulations affecting abortion must be considered in light of the medical profession's standards of judgment. *City of*

Akron v. *Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 434 (1983) (stating that a regulation of abortion that "departs from accepted medical practice" may not be upheld), *overruled on other grounds by Planned Parenthood* v. *Casey*, 505 U.S. 833 (1992);[11] *Planned Parenthood* v. *Danforth*, 428 U.S. 52, 79 (1976) (striking down abortion ban that would have "force[d] a woman and her physician to terminate her pregnancy by methods more dangerous than the method outlawed"); see also *Simopoulos* v. *Virginia*, 462 U.S. 506, 519 (1983) (upholding requirement that second-trimester abortions be performed in licensed clinics because the requirement "comport[s] with accepted medical practice, and leaves the method and timing of the abortion precisely where

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[11] Justice Kennedy's suggestion that *Casey* "repudiated" this aspect of *Akron* is misplaced. *Stenberg* v. *Carhart*, 530 U.S. 914, 969 (2000) (Kennedy, J., dissenting). While Justice Kennedy is correct that in overruling *Akron*'s informed consent holding, *Casey* repudiated those portions of *Akron* which suggested that deference to the individual physician was mandated, *compare Planned Parenthood* v. *Casey*, 505 U.S. 833, 884 (1992) (plurality opinion), *with Akron*, 462 U.S. at 445, *Casey* did nothing to curtail the deference the *Akron* Court had paid to professional standards in striking down the hospitalization requirement, *compare Casey*, 505 U.S. at 881-86 (plurality opinion), *with Akron*, 462 U.S. 430 n.11; *id.*, at 435-36; *id.* at 437 (noting: "ACOG [American College of Obstetricians and Gynecologists] no longer suggests that all second–trimester abortions be performed in a hospital. It recommends that abortions performed in a physician's office or outpatient clinic be limited to 14 weeks of pregnancy, but it indicates that abortions may be performed safely in 'a hospital-based or in a free-standing ambulatory surgical facility,' until 18 weeks of pregnancy. These developments, and the professional commentary supporting them, constitute impressive evidence that-at least during the early weeks of the second trimester-D & E abortions may be performed as safely in an outpatient clinic as in a full-service hospital.") (internal citations omitted); *see also id.* at 437 n.26 (discussing the government's own reliance on ACOG standards.). Indeed, as this Court has recognized, what is accepted medical practice according to ACOG is highly relevant to determining if there is "substantial medical authority" in support of a procedure. *E.g.*, *Stenberg*, 530 U.S. at 938; *Akron*, 462 U.S. 416.

they belong—with the physician and the patient"). Viewed through the same lens that surgical professionals would, it becomes clear that intact D&E has been shown to be safe and to provide tangible and substantial health benefits. *Supra* Part I.B.

This law unquestionably jeopardizes women's health, with a veiled pretense of concern for safety. To uphold the Act, then, would mark a sea change in this Court's jurisprudence because never before has this Court held that a government interest in a particular abortion regulation outweighed the combined strength of the state's and the woman's interest in her health.

A. Women's Health Is Primary To, If Not Dispositive Of, The Constitutional Analysis.

Joining an unbroken line of this Court's precedents, *Stenberg* v. *Carhart* held that "a State may promote but not endanger a woman's health when it regulates the methods of abortion." 530 U.S. 914, 931 (2000) (collecting cases); *accord Ayotte* v. *Planned Parenthood*, 126 S. Ct. 961, 967 (2006); see *Casey*, 505 U.S. at 879 (plurality opinion). Where this Court has recognized that an interest in protecting women's health is implicated by a potential restriction on abortion, that interest has *always* overcome the competing interests advanced by the state. See, *e.g.*, *Ayotte*, 126 S. Ct. at 967; *Stenberg*, 530 U.S. at 929-31; *Thornburg* v. *Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 769 (1986), *overruled on other grounds by Casey*, 505 U.S. 833; *Danforth*, 428 U.S. at 79; see *Colautti* v. *Franklin*, 439 U.S. 379, 400 (1979) (women's health is "paramount"). This is hardly surprising, for not only is women's health a fundamental right in abortion jurisprudence, but women's health and safety are themselves compelling state interests. See, *e.g.*, *Casey*, 505 U.S. at 977 (Rehnquist, C.J., dissenting) (state interest in women's health); *Danforth*, 428 U.S. at 80-81 (upholding recordkeeping requirements directed at preservation of women's health); *Akron*, 462 U.S. at 428-29,

430-31, 443; *id.* at 459 (O'Connor, J., dissenting) (state has interests in "the areas of health and medical standards," as well as "maximum" safety for women).

A woman's fundamental right to her health is so great that even post-viability, when the state's interest in potential life is so strong as to permit the state to ban abortion altogether, this Court has pointedly refused to allow that interest to override the woman's (and the state's) interests in her health. When necessary for the health of the woman, an abortion must be allowed, even after viability. *Casey*, 505 U.S. at 879 (plurality opinion) ("'subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother'") (quoting *Roe* v. *Wade*, 410 U.S. 113 164-65 (1973)). These longstanding principles require that the decision below be affirmed because the Act will put women's health at risk.

The *Stenberg* Court correctly recognized that an intact approach to D&E offers safety advantages for women. See generally 530 U.S. at 931-37 (discussing general and specific advantages of intact variation.). In doing so, the *Stenberg* Court took the modest step of affirming what physicians had discovered to be true over the years in which they had explored different variations of D&E, seeking to provide the safest and most effective procedures for their patients. *Supra* at 12-17. Indeed, this Court properly recognized that considerable physician experience with intact D&E—which has grown dramatically since *Stenberg*—provided strong evidence of the benefits of the surgical innovation. This conclusion is bolstered by the fact that dismemberment D&E constituted an evolutionary alternative to labor induction nearly two decades earlier. See *supra* at 13-14.

B. Banning An Intact Approach To D&E Denies Women A Potential Health Benefit By Increasing The Health Risks They Face.

Some of *Stenberg*'s critics do not deny that women's interest in their health is so great that it cannot be overcome by the state's competing interests. Instead, they have charged that this and similar statutory schemes pass constitutional muster because there has been no showing that such bans "create[] a significant health risk." *Nat'l Abortion Fed'n* v. *Gonzales*, 437 F.3d 278, 291 (2d Cir. 2006) (Walker, C.J., concurring); see also, *e.g.*, *Stenberg*, 530 U.S. at 966-72 (Kennedy, J., dissenting); *Planned Parenthood* v. *Doyle*, 162 F.3d 463, 478 (7th Cir. 1998) (Manion, J., dissenting).

For example, Chief Judge Walker asserted that "in all circumstances there are objectively 'safe' alternatives" to intact D&E. *Nat'l Abortion Fed'n*, 437 F.3d at 291. Based on his posited notion of objective "safety," Chief Judge Walker characterized the ban as a mere "den[ial to] some women [of] a potential health *benefit* over an objectively 'safe' baseline; it does not establish that such a statute would pose a constitutionally significant health *risk*." *Id.* In essence, his argument is that alternatives exist that are "safe enough."

Chief Judge Walker's artificial distinction between the denial of a health benefit and an increased health risk does not withstand scrutiny. There is no such thing as a completely "safe" surgery, because by definition surgery disrupts the physical integrity of the body, and all such disruptions involve some harm. Although years of surgical experience brought about consensus that D&E is a relatively safe procedure which should continue to be practiced to maximize the health of women who need abortions, D&Es of all variations, like all surgical procedures, carry risks. When intact procedures reduce those real and potentially catastrophic risks, it makes no sense to talk about a dismemberment approach to D&E as inherently or objectively

safe. Moreover, any such discussion of an objective level of safety accompanying one approach to abortion or another is inherently flawed because, in every event, any approach to abortion is considerably safer in the abstract than child birth. David A. Grimes, *Estimation of Pregnancy-Related Mortality Risk by Pregnancy Outcome, United States, 1991-1999*, 194 Am. J. Obstet. & Gynec. 92, 92-93 (2006) (concluding "[t]he relative [mortality] risk associated with live birth was 12.4 times higher" than that associated with legal abortion).

There is no distinction between risk and benefit in the D&E context. Rather, they are two inseparable sides of the same coin. See Beauchamp & Childress, *supra*, at 194-95 (stating "[b]enefit" compares to harm, as "risk"—which can refer to chance of harm, or the potential magnitude of harm—compares to "probability of benefit"). Like all patients, a woman terminating a pregnancy in the second trimester seeks to minimize the risk of harm associated with the procedure. If the physician concludes that D&E with intact removal will reduce the risks for a particular patient, Chief Judge Walker would apparently recognize that such a patient is receiving a health benefit. In his view, however, withholding this benefit is permissible because the less safe procedure still satisfies some arbitrary but minimalist notion of "safe." Yet the health benefit denied here is an increase in safety—in other words, the reduction of risk. Accordingly, when this "benefit" is denied, the woman is not merely deprived of an advantage, but is inherently put at risk.

Surgeons simply do not think of safety in the kind of absolute terms Chief Judge Walker has posited. It is senseless for a court to attempt to evaluate the magnitude of a health benefit against some objective notion of what is "safe." Cf. *United States* v. *Rutherford*, 442 U.S. 544, 555 (1979) ("Few if any drugs are completely safe in the sense that they may be taken by all persons in all circumstances without risk."). To the contrary, even medical procedures that are performed safely in the overwhelming majority of cases

present health risks, and in particular cases the minimal risk manifests as substantial injury. See, *e.g.*, *Fulton* v. *Loucks*, 947 F.2d 944 (6th Cir. 1991) (table) (appeal of wrongful death action by parents whose son died days after having his tonsils removed).

In surgery and in medical practice generally, physicians always strive for the safest treatment *under the circumstances*. In any given surgery, factors such as the individual patient's health history and his or her use of medications, as well as the physician's judgment as to which risks are acceptable to the overall health of the patient make the concept of "safety" in the context of surgery transient at best. In addition, risks are always understood in relation to benefits. A certain level of risk might be acceptable for a procedure that excises a deadly cancer and unacceptable for elective surgery. Finally, the circumstances as they present when the surgeon initially assesses treatment options may evolve during the procedure, altering what actions are and are not safe. These variables dispel any claims that an "objectively 'safe' baseline" exists. Cf. *Anderson* v. *Weinsweig*, 34 Fed. Appx. 916, 917 (4th Cir. 2002) (per curiam).[12]

The enhanced safety of intact D&E is well-recognized by physicians. Of course, patient- or fetus-specific circumstances known at the outset (for example, gestational age) may make an actual intact extraction unlikely. Likewise, circumstances that arise during the procedure may frustrate

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[12] In *Anderson*, the Fourth Circuit detailed the multiple variables faced by a physician where a patient's foot bothered him before undergoing planned brain surgery. As the Fourth Circuit noted, the doctor determined "the problems arose from constricted blood flow; that this constriction could not be treated without administering blood thinners; that these blood thinners, combined with inevitable delays in performing the brain surgery, might exacerbate the problems in [the patient's] brain; and that it was therefore appropriate to proceed with the brain surgery even though doing so might have adverse consequences for [the patient's] foot," and indeed the delay led to amputation of two toes. 34 Fed. Appx. at 917.

the attempt to accomplish the removal intact. In addition, physician training or protocols, or patient medical circumstances may result in less dilation and less chance of intact removal. What matters is that physicians be permitted to exercise their professional judgment based on their experience and training and the state of the medical art to perform a D&E procedure in the manner that maximizes patient safety and health. See *Stenberg*, 530 U.S. at 923-29.

A responsible physician who is performing a second trimester abortion would not merely ask whether an alternative approach satisfies some contrived notion of "safe enough." Physicians' ethical commitments to their patients require that they maximize patient safety within the parameters of learned professional judgment. See Beauchamp & Childress, *supra*, at 115 (the principle of beneficience requires one to prevent harm, remove harm and do good; the principle of nonmaleficence requires one to not inflict harm); ACOG, *Ethics in Obstetrics and Gynecology* at 4 (2d ed. 2004) (same); *Planned Parenthood Ass'n* v. *Ashcroft*, 462 U.S. 476, 487 (1983); *Akron*, 462 U.S. at 434 (acknowledging value of accepted medical standards); *Dent* v. *W. Virginia*, 129 U.S. 114, 122-23 (1889). A law criminalizing the safest methods of abortion for particular patients—especially where the banned methods accord with substantial medical authority—would put physicians in a terrible ethical dilemma: betray their duty to their patient, or betray the obligation to follow the law. Just as deference has been paid to physicians' collective expertise as they have developed innovative medical procedures through years of observation and refinement, deference is owed when surgeons determine how to put their knowledge, training and experience to use to advance health and safety in a given case. Because physicians must seek to optimize safety for every patient they treat, a prohibition against safe abortion methods undermines their collected experience and the resulting procedures carry enhanced risks. A government restriction that deprives

physicians of the full range of options within their professional medical judgment and expertise—and in accord with authoritative medical standards—thus offends the constitutional requirement that women not be forced to undergo methods of abortion that are riskier than those that would be available absent the restriction. See *Stenberg*, 530 U.S. at 931.

III. ADOPTING THE GOVERNMENT'S POSITION WOULD MARK A SEA CHANGE IN THIS COURT'S ABORTION JURISPRUDENCE.

This Court's precedents share an unwavering commitment to protecting maternal health as the predominant consideration in determining the constitutionality of a restriction on abortion. The constitutional analysis the Government advocates—which repudiates this framework—cannot be squared with this Court's precedents.

A. This Court Should Reject The Claim That Preventing Abortion Which "Resembles Infanticide" Is A Compelling Interest Sufficiently Strong To Overcome Women's Interest In Access To The Safest Abortion Procedure.

The Government urges this Court to recognize a novel compelling state interest, *viz.*, "prohibiting a particular type of abortion procedure that closely resembles infanticide." U.S. Br. 28. The Government goes so far as to argue that this "interest" in preventing procedures resembling infanticide is "*no less compelling*" than its interest in protecting human life, *id.* (emphasis added); in turn, the Government's argument suggests that this novel interest also outweighs the woman's interest in safety. See *id.* at 10, 24, 27; see also *id.* at 28.[13]

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[13] Comparing the abortion procedures at issue in this case—all of which occur prior to viability—to infanticide is curious from the outset. *See, e.g.*, *Oxford English Dictionary* (2d ed. 1989) (defining infanticide and its origins in a manner presuming viability); *American Heritage Dictionary of the English Language* (4th ed. 2000) (defining "infanticide" as "*1.* The

The Government's effort to elevate its purported interest in preventing abortion that supposedly resembles infanticide to one so compelling as to outweigh the paramount interest in women's health should be rejected.

First, in advancing the infanticide interest as controlling, the Government turns the prevailing constitutional analysis on its head. Without doctrinal foundation, the Government attempts to subvert the heretofore predominant interests in women's health, the potential for human life and medical progress. Adopting the Government's proposed compelling interest where, as here, the woman has already determined that the pregnancy should be terminated and where the procedure is occurring prior to viability, would deal a massive blow to the woman's health interests. Focusing on *how* the pregnancy will be terminated, rather than the nature of the health deprivation, would rework this Court's cases that "have repeatedly invalidated statutes that in the process of regulating the *methods* of abortion, imposed significant health risks." *Stenberg*, 530 U.S. at 931 ("a risk to a women's [sic] health is the same whether it happens to arise from regulating a particular method of abortion, or from barring abortion entirely"). If the Court were to adopt the moral condemnation approach that the Government urges, the result would be breathtaking, allowing the interest in women's health to be trumped even pre-viability where the state interests have long been recognized as "considerably weaker than postviability." *Stenberg*, 530 U.S. at 930 (citing *Casey*, 505 U.S. at 870).

Second, this Court recently rejected a criminalization argument by the federal government directly parallel to the one it now advances. See *Ashcroft* v. *Free Speech Coalition*, 535 U.S. 234 (2002). In enacting the Child Pornography

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act of killing an infant. *2.* The practice of killing newborn infants."). *See also Stenberg*, 530 U.S. at 946-47 (Stevens, J., concurring) (notion that one form of D&E "is more akin to infanticide than the other, or that the State furthers any legitimate interest by banning one but not the other, is simply irrational").

Prevention Act, Congress sought to go beyond the preexisting ban on child pornography by criminalizing images that looked like child pornography but did not involve actual children. Reasoning that the indirect government interest in prohibiting the *appearance of* child pornography was not sufficient to outweigh the First Amendment protection at issue, the Court held that only direct harm to real children could justify such an imposition on the fundamental right. See *id.* at 248-51. Moreover, the Court squarely rejected the Government's argument that prohibiting otherwise protected conduct as a means to prevent already impermissible actions was a compelling interest that allowed infringement of the speech right. See *id.* at 254-55. Applied here, the same fundamental rights analysis prevents the government from prohibiting intact D&E, which would otherwise be lawful, as an attempt to prevent infanticide, which is already subject to criminal penalty.

Finally, this Court's precedent forecloses the Government's effort to impose morality as a compelling interest that would override a fundamental right. In *Lawrence* v. *Texas*, 539 U.S. 558 (2003), this Court firmly rejected the proposition that moral concerns alone could ground a statute that infringes upon the right to autonomy protected by the due process clause. *Id.* at 571 ("These [moral] considerations do not answer the question before us, however."). The fact of moral objection standing alone was insufficient to prove that the morality rationale would constitutionally justify "us[ing] the power of the State to enforce these views on the whole society through operation of the criminal law." *Id.*; see also *Romer* v. *Evans*, 517 U.S. 620, 634-35 (1996) (legislation cannot be justified by animosity toward a class of persons); *Lawrence*, 539 U.S. at 583 (O'Conner, J, concurring) ("moral disapproval" is not a legitimate state interest sufficient to ban one form of sodomy but not another). Just as in the equal protection context where it would not even rise to the level of a rational basis to express animus to a particular group, see,

e.g., *United States Dep't of Agric.* v. *Moreno*, 413 U.S. 528, 534 (1973) (holding "a bare . . . desire to harm a politically unpopular group cannot constitute a legitimate government interest") (emphasis omitted); *Romer*, 517 U.S. at 635 (finding "the breadth of the amendment [was] so far removed from [its asserted] justifications" that it was not "directed to an identifiable legitimate purpose or discrete objective" but "raise[d] the inevitable inference that it [wa]s born of animosity"), in this case the displeasure with a certain type of incidental procedure could never rise to the level of a compelling government interest sufficient to overcome a fundamental right. See *Saenz* v. *Roe*, 526 U.S. 489, 499 n.11, 506 (1999) ("If a law has no other purpose . . . than to chill the assertion of constitutional rights by penalizing those who choose to exercise them, then it [is] patently unconstitutional"; thus, a purpose to deter welfare applicants from migrating to California was an "unequivocally impermissible" government interest) (alteration and omission in original) (quotation omitted). The Act's overbreadth and incomplete-reasoning—no more than direct attacks on otherwise-protected conduct—give rise to a strong inference of simple animus, assertions of moral rectitude notwithstanding, which this Court has never dignified as a constitutional basis for an infringement on a fundamental right.

B. This Court Rightly Has Never Held That A Restriction On Abortion May Survive Even Though It Would Increase Risks To Women.

Although the Government claims that prohibiting intact D&E would not impinge on women's health interests, it also asserts that even if intact D&E reduces health risks, the increased risks to the woman associated with banning such procedures are nonetheless insufficient to require constitutional protection. See U.S. Br. 28. In doing so, the Government urges this Court to hold for the first time that the "relative strength of the government's interests prohibiting partial birth abortion"—its asserted interest in the potential

for life and the "severe moral condemnation" for a procedure supposedly resembling infanticide—supersede the state's and the woman's combined interest in preserving her health. See *id.*; contra *Stenberg*, 530 U.S. at 931 ("we cannot see how the interest-related differences *could make any difference* to the question at hand, namely, the application of the 'health' requirement") (emphasis added).

Because the state's interest in potential life has always proved insufficient to overcome the combined interest of the state and the woman in her health, it would be unprecedented and illogical to allow the novel government interest asserted here to surpass the health interests. Even if the Court were willing to consider taking the fateful step of concluding that some interest could overcome the combined interest in women's health, this would be a particularly poor occasion to do so. As noted above, the newly asserted government interest is of a purely moral dimension; the structure of even a narrowly drawn and clearly worded ban—which this is not—would only incidentally affect the number of abortions performed. Such a ban would be certain to channel at least some women into undergoing riskier abortions. Instead of fundamentally reworking abortion law in this country, this Court should adhere to unbroken years of precedent ensuring that abortion regulations do not undermine the medical community's commitment and ability to protect women's health.

CONCLUSION

For the foregoing reasons, the judgment of the United States Court of Appeals for the Ninth Circuit should be affirmed.

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ALBERTO R. GONZALES, ATTORNEY GENERAL,

Petitioner,

v.

PLANNED PARENTHOOD FED. OF AMERICA, INC., *ET AL.*,

Respondents.

On Writ of Certiorari
to the United States Court of Appeals
For the Ninth Circuit

Brief of *Amici Curiae* Professor Hadley Arkes and The Claremont Institute Center for Constitutional Jurisprudence In Support of Petitioner

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QUESTIONS PRESENTED

1. Whether the Partial-Birth Abortion Ban Act of 2003 is a valid exercise of Congress's authority under the Commerce Clause (either as originally understood or as presently interpreted)?

2. Whether, apart from the Commerce Clause, Congress had the constitutional authority to enact the Partial-Birth Abortion Ban Act of 2003?

3. Whether this Court's enunciation of an abortion right permits it to lay claim to the inherently legislative authority to determine the scope and weight to be given to that right?

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No. 05-1382

In The

Supreme Court of the United States

ALBERTO R. GONZALES, ATTORNEY GENERAL,

Petitioner,

PLANNED PARENTHOOD FED. OF AMERICA, INC., *ET AL.*,

Respondents.

On Writ of Certiorari
to the United States Court of Appeals
For the Ninth Circuit

Brief of *Amici Curiae* Professor Hadley Arkes and
The Claremont Institute Center for Constitutional
Jurisprudence In Support of Petitioner

INTEREST OF *AMICUS CURIAE*[1]

The Claremont Institute for the Study of Statesmanship and Political Philosophy is a non-profit educational foundation whose stated mission is to "restore the principles of the American Founding to their rightful and preeminent authority in our national life," including the

[1] The Claremont Institute Center for Constitutional Jurisprudence files this brief with the consent of all parties. The letters granting consent have been previously filed or are being filed concurrently. Counsel for a party did not author this brief in whole or in part. No person or entity, other than *amici curiae*, its members, or its counsel made a monetary contribution specifically for the preparation or submission of this brief.

principle at issue in this case that just governments are established to protect the unalienable rights with which all human beings "are endowed by their Creator," including the right to life. The Institute pursues its mission through academic research, publications, scholarly conferences and, via its Center for Constitutional Jurisprudence, the selective appearance as *amicus curiae* in cases of constitutional significance. The Institute and its affiliated scholars have published a number of books, monographs, and articles of particular relevance here, including Glen E. Thurow, *Turning the Tide on Abortion, in* MORAL IDEAS FOR AMERICA (Larry P. Arnn and Douglas A. Jeffrey, eds., 1993); John C. Eastman, *Stare Decisis: Conservatism's One-Way Ratchet Problem*, in THE COURTS AND THE CULTURE WARS (Bradley Watson, ed., 2002); John C. Eastman, *Judicial Review of Unenumerated Rights: Does Marbury's Holding Apply in a Post-Warren Court World?* 28 HARV. J. L. & PUB. POL'Y 713 (2005).

The Claremont Institute Center for Constitutional Jurisprudence has participated as *amicus curiae* before this Court in several cases addressing important constitutional issues, including *Hamdi* v. *Rumsfeld*, 542 U.S. 507 (2004); *Elk Grove Unified Sch. Dist.* v. *Newdow*, 542 U.S. 1 (2004); *Zelman* v. *Simmons-Harris*, 536 U.S. 639 (2002); *Solid Waste Agency of N. Cook Cty. v. U.S. Army Corps of Engineers*, 531 U.S. 159 (2001); *Boy Scouts of America* v. *Dale*, 530 U.S. 640 (2000); and *United States v. Morrison*, 529 U.S. 598 (2000).

Hadley Arkes, a member of the board of advisors of the Center for Constitutional Jurisprudence, is the Ney Professor of Jurisprudence at Amherst College, where

he has taught since 1966. He was the main architect of the Born-Alive Infants' Protection Act of 2002, and led the testimony for that Act in hearings before the House Judiciary Subcommittee of the Constitution. The Partial-Birth Abortion Ban Act of 2003, at issue here, springs from the same premises and raises the same questions about the constitutional grounds for federal legislation touching on abortion. Professor Arkes's interest is in making a case that does not depend on the Commerce Clause for that national authority.

Professor Arkes is the author of six books, published by the university presses at Princeton and Cambridge. In most of those books, he has dealt with the matter of abortion in its moral and legal dimensions, or he has dealt with the constitutional grounds on which the arguments would finally rest. Among those books are: FIRST THINGS (Princeton 1986); BEYOND THE CONSTITUTION (Princeton 1990); THE RETURN OF GEORGE SUTHERLAND (Princeton 1994); and NATURAL RIGHTS & THE RIGHT TO CHOOSE (Cambridge 2002). In addition, his writings have appeared in law journals, as well as newspapers and journals addressed to a wider audience, and provide the foundation from which the arguments in this brief are drawn.

SUMMARY OF ARGUMENT

Although not addressed by the courts below, it is important to consider, as a threshold matter, whether the Partial-Birth Abortion Ban Act of 2003, 18 U.S.C. § 1531, is an exercise of powers delegated to Congress by the Constitution. The Act itself appears to rest on the Commerce Clause. In Part I below, we contend that such a claim cannot be sustained as that Clause was

originally understood, but we then note that the Act is easily a valid exercise of Commerce Clause authority as currently viewed by a majority of this Court.

In Part II, we offer another ground for Congress's authority, one which parallels the authority claimed by this Court when it rendered its initial and subsequent abortion decisions. Because it would be incompatible with our constitutional system, which assigns the legislative power to Congress, for the federal courts to have jurisdiction in an arena that is closed to the federal legislature, Congress's authority with respect to abortion must be co-extensive with the authority that has been claimed by this Court over the subject.

Finally, in Part III, we contend that Congress must be given a great deal of deference as it attempts to define, legislatively, the parameters of the right this Court has recognized, and the weight to be given to that right when it comes into conflict with other fundamental rights of at least equal import. Under that standard, and the principles of constitutionalism upon which it is based, the Partial-Birth Abortion Act of 2003 should be upheld.

ARGUMENT

I. Congress's Commerce Clause Authority to Ban Partial-Birth Abortion.

The Partial-Birth Abortion Ban Act of 2003, 18 U.S.C. § 1531 (the "Act") announces in its opening sentence that it forbids any physician "*in or affecting interstate or foreign commerce* [from] knowingly perform[ing] a partial-birth abortion." (Emphasis added). Obviously designed to permit regulation of partial-birth

abortions to the full extent of the power delegated to Congress under the Commerce Clause, the Act's reliance on the Commerce Clause is nevertheless problematic, at least as that Clause was originally understood.

Judge Casey noted in the parallel case out of New York, *National Abortion Federation* v. *Ashcroft*, 330 F. Supp. 2d 436, 440 n.1 (S.D.N.Y. 2004), that no plaintiff in the case before him challenged the authority of Congress to legislate on this matter under the Commerce Clause. And none of the Courts of Appeals that have considered the statute have dealt with the lurking Commerce Clause issue. But it is never out of season for this Court to weigh seriously the constitutional ground offered by Congress for its action—even before turning to consider prohibitions found elsewhere in the text of the Constitution, or limitations even more refined, found outside that text of the Constitution. Such an inquiry is part of a constitutional discipline that puts boundaries or restraints on the reach of the federal authority, and it applies as much to Congress as to the other branches of the national government.

It is well established and recently reaffirmed by this Court that the Constitution creates a federal government of limited and enumerated powers, with the bulk of powers reserved to the States or to the people. *See e.g., United States* v. *Lopez*, 514 U.S. 549, 552 (1995); U.S. Const. Amend. X. As James Madison explained:

> The powers delegated by the proposed Constitution to the federal government are few and defined. Those which are to remain in the State governments are numerous and indefinite. The former will be exercised principally on external

> objects...The powers reserved to the several States will extend to all the objects which, in the ordinary course of affairs, concern the lives, liberties and properties of the people; and the internal order, improvement, and prosperity of the State.

THE FEDERALIST NO. 45, at 292-93 (J. Madison) (Clinton Rossiter, ed., 1961); *see also* The Federalist No. 17, at 118 ("The administration of private justice between the citizens of the same State, the supervision of agriculture and of other concerns of a similar nature, all those things, in short, which are proper to be provided for by local legislation, can never be desireable cares of a general jurisdiction").

It is equally well settled that chief among the powers reserved to the States is the police power—the power to protect the "safety, health, peace, good order, and morals of the community." *Cowley* v. *Christensen*, 137 U.S. 86, 89 (1898); *see also, e.g.*, *Barnes* v. *Glen Theatre, Inc.*, 501 U.S. 560, 569 (1991); *New State Ice Co.*, v. *Liebmann*, 285 U.S. 262, 304 (1932). Surely the power to impose restrictions on abortion—particularly the late-term, partial-birth abortions at issue here—falls squarely within this area of police powers reserved to the states rather than delegated to the national government.

To be sure, the power to regulate interstate commerce is one of the powers expressly delegated to the national government, but the original meaning of both "interstate" and "commerce" must be stretched beyond recognition for the statute at issue here to be a valid exercise of that power in all but a few cases where the

statute's prohibition might be brought to bear. Quite simply, the performance of an abortion (as with any medical procedure) is not "commerce" at all, much less "interstate commerce," as those words were originally understood. *See, e.g., Lopez*, 514 U.S., at 586-88 (Thomas, J., concurring).

Moreover, the obvious aim of the statute is not to prohibit the performance of a partial-birth abortion on an interstate railway or along side an interstate highway, or even to prevent interstate travel for the purpose of obtaining an abortion. It is, rather, to prohibit a particularly gruesome form of abortion altogether, not because of its impact on commerce, but because of its moral repugnancy. That is a quintessential exercise of the police power reserved to the states, using economic impact as mere pretext, and as this Court long ago noted, "should Congress, under the pretext of executing its powers, pass laws for the accomplishment of objects not entrusted to the government; it would become the painful duty of this tribunal ... to say that such an act was not the law of the land." *McCulloch* v. *Maryland*, 17 U.S. (4 Wheat.) 316, 423 (1819); *see also Cohens* v. *Virginia*, 19 U.S. (6 Wheat) 264 (1821) (noting that Congress had no authority to punish murder or felonies generally, except in areas where it enjoyed plenary powers such as the District of Columbia).

Of course, existing precedent supports a much broader view of the Commerce Clause authority of Congress—more than broad enough to sustain the Act of Congress at issue here. Despite recent attempts by this Court in such cases as *Lopez*, *Morrison*, and *Solid Waste Agency* to restore the older sense of the Com-

merce Clause, those efforts never really confronted the much more expansive view of the Commerce Clause first articulated in such New Deal-era cases as *Wickard* v. *Filburn*, 317 U.S. 111 (1942), *United States* v. *Darby*, 312 U.S. 100 (1941), and *National Labor Relations Bd.* v. *Jones & Laughlin Steel Corp.*, 301 U.S. 1 (1937), and confirmed more recently in *Gonzales* v. *Raich*, 545 U.S. 1 (2005). As a result, Congress has been left with virtually unfettered power to regulate under its Commerce Clause authority. The Partial-Birth Abortion Ban Act of 2003 fits easily on the permissible side of the line this Court has drawn, for several reasons.

First, abortion services, like all medical services, in most instances involve an economic transaction between a woman who seeks the abortion and the physician who is compensated for providing the abortion. The cumulative impact of those economic transactions, when viewed in the aggregate as *Wickard* permits, qualifies as a "substantial effect" on interstate commerce subjecting the abortion procedure to the Commerce Clause regulatory authority of Congress as long as that test remains a part of this Court's Commerce Clause jurisprudence. *But see Lopez*, 514 U.S., at 587-88 (Thomas, J., concurring) (challenging the legitimacy of the substantial effects test); *Morrison*, 529 U.S., at 627 (Thomas, J., concurring) ("the very notion of a "substantial effects"...is inconsistent with the original understanding of Congress' powers and with this Court's early Commerce Clause cases").

Second, the statute does contain a jurisdictional requirement (albeit one that simply parrots the expansive Commerce Clause authority previously recognized by

this Court), thus distinguishing it from such cases as *Lopez*. *See Lopez*, 514 U.S., at 561.

Third, the impact on interstate commerce—even apart from the abortion transaction itself—is much less attenuated than in cases such as *Morrison* and *Solid Waste Agency*. It is a certainty that the nation loses a future economic actor with each abortion, for example. One need not "pile inference upon inference" to discern a large cumulative impact on the national economy from such a practice, therefore, particularly when one considers all the lost diaper sales, school supplies, vacation travel, college tuition, etc., that might otherwise occur but for abortion.

For these reasons and more, the Partial-Birth Abortion Ban Act of 2003 is clearly a valid exercise of Congress's Commerce Clause authority, as currently understood by this Court.[2]

II. The Fourteenth Amendment as a Source of Congressional Authority.

If we should instead to recur to first principles—a task that this issue demands more than most—we will have to look elsewhere for a more certain source of

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[2] While we think that outcome inconsistent with the original understanding, and while we invite the Court to address the Commerce Clause issue lurking in this case, we ask that any such consideration be done consistently, that existing precedent to the contrary be overturned rather than artificially distinguished. There is already enough of an "abortion distortion" in our law for this Court to deny Commerce Clause authority for the Act at issue here while leaving in place the otherwise expansive interpretation of the clause. *See, e.g.*, *Hill* v. *Colorado*, 530 U.S. 703, 753-65 (2000) (Scalia, J., dissenting).

congressional authority to regulate in this arena of obvious state primacy before proceeding to address whether the Act contravenes certain constitutional or extra-constitutional prohibitions on the legislative power.

Congress is here seeking to protect children at the point of birth, marking the plausible limits that must affect even a right of abortion, taken in its fullest sweep. Congress, by its own assertion, is also seeking to protect the character and integrity of the medical profession by barring surgeons from being lured into surgical procedures that may be regarded as deeply wrong and even corrupting. Partial-Birth Abortion Ban Act of 2003, Pub. L. No. 105, § 2(14)(G), 117 Stat. 1201, 1205 ("In addition to promoting maternal health, such a prohibition will draw a bright line that clearly distinguishes abortion and infanticide, that preserves the integrity of the medical profession, and promotes respect for human life"). Those kinds of concerns, bearing on matters of moral consequence, or the protection of persons from injuries suffered at the hands of other, private persons, are concerns that have traditionally fallen within the police powers of the State and local government.

Traditionally, but not exclusively. Under the Civil Rights Acts and the Fourteenth Amendment, for example, the authority of Congress has been flexed to protect people of minority races from assaults at the hands of private thugs of varying degrees of organization. They could be the assembled cohorts of the Ku Klux Klan, members of the lynching party brought forth in an ad hoc way, or private persons in collusion with the authorities. *See, e.g., United States* v. *Price*, 383 U.S. 787

(1966) (applying a federal statute to law enforcement officials who killed three civil rights workers).

The difficulty with the civil rights analogy, though, is that in the context of the Civil Rights Act, Congress was reaching private conduct where states had failed to act (or worse, had acted in collusion with private actors), depriving some persons within their jurisdiction of the equal *protection* of the laws in the truest meaning of that phrase. There is no such state action here. Quite the contrary—many of the states have persisted in their attempts to protect the weakest and most innocent of our fellow human beings despite this Court's series of abortion rulings since 1973.[3]

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[3] *See, e.g.*, 720 Ill. Comp. Stat. Ann. 510/1 (West 2006) (acknowledging that the unborn is a human from time of conception and entitled to right to life and would be afforded such protection if not for the federal right to abortion); Cal. Pen. Code § 187 (2006); La. Rev. Stat. Ann. § 1299.35.0 (West 2006); Mo. Rev. Stat. § 1.205 (2006); S.D. Codified Laws § 22-17-7 (2006) (finding that "life begins at the time of conception"); Ariz. Rev. Stat. §13-1103 (2006); La. Rev. Stat. Ann. § 14:32.5-32.8 (2006); Mich. Penal Code § 750.322 (2006); Minn. Stat. § 609.2661 (2005); Nev. Rev. Stat. Ann. § 200.210 (2006); Okla. Stat. Ann. tit. 21, § 713 (West 2006); Wis. Stat. §940.04 (2006) (extending criminal law protection to the unborn outside of abortion); Ariz. Rev. Stat. § 13-3603.01 (2006); Fla. Stat. Ann. § 782.34 (2006); Ga. Code Ann. § 16-12-144 (2006); Mont. Code Ann., § 50-20-108 (2005); Neb. Rev. Stat. § 28-328 (2006); Ohio Rev. Code Ann. § 2919.151 (West 2006); Utah Code Ann. § 76-7-301.1(3) (2006) ("It is the intent of the Legislature to protect and guarantee to unborn children their inherent and inalienable right to life as required by Article 1, Section 1 and 7, Utah Constitution."); Va. Code Ann. § 18.2-71.1 (2006) (criminalizing partial-birth abortion); 18 Pa.C.S. § 3211 (2005) (restricting abortions after the gestational age of the unborn child is 24 weeks or more).

That is not the end of the matter, of course. The distinction between "citizen" (defined as those "*born*" in the United States and subject to its jurisdiction) in the Privileges or Immunities Clause of the Fourteenth Amendment and "person" in the Due Process and Equal Protection clauses certainly lends itself to the credible argument that "persons" conceived but not yet born fall under the umbrella of the latter two clauses. Admittedly, that distinction does not appear to have been within the contemplation of those who drafted or ratified the Constitution, but the lack of attention to the subject was undoubtedly because the practice was so contrary to the most basic of human rights—the inalienable right to life, to use the Declaration's phrase—rather than that the citizens and legislators of the day thought abortion to be acceptable. As a result, we should not presume that the Fourteenth Amendment meant to exclude children in the womb from the class of "persons" protected by the Fourteenth Amendment merely because the subject of abortion was not debated in 1866.

This Court has recognized in other contexts, for example, that the word "persons" encompasses a wider category than the word "citizens." Visitors from abroad, resident aliens, and illegal immigrants alike may be protected from the lawless assault on their lives even without the need to show passports or papers of citizenship, and cannot be deprived of their life or liberty without due process, merely because they are "persons." *See, e.g., Plyler* v. *Doe,* 457 U.S. 202, 211-212 (1982); *Yick Wo* v. *Hopkins*, 118 U.S. 356, 369 (1886).

In the commonsense understanding, "persons" are human beings. To ask when human beings come under

the protection of the laws is virtually to ask: When do they come to exist? When do their inalienable rights as "persons" attach? The answer given by James Wilson was that basic, fundamental rights are acquired as soon as a person begins to be:

> In the contemplation of law, life begins when the infant is first able to stir in the womb. By the law, life is protected not only from immediate destruction, but from every degree of actual violence, and, in some cases, from every degree of danger.

James Wilson, *Of the Natural Rights of Individuals*, in 2 THE WORKS OF JAMES WILSON 597 (1967) (1804). We do not think that Wilson meant merely "quickening" when he noted the point at which infants are first able to "stir in the womb." We assume that he meant "as soon as we know that the child is there, present in the womb and alive." We assume then that his understanding here would readily incorporate the understandings of modern embryology—that a self-organizing life, powering its own development, is present from the first moments, with the zygote that is formed with the union of the male and female gamete. And even without modern embryology, Wilson apparently understood that the organism in the womb does not change species in the course of its development. It does not *become* human, and it is not merely a *potential* human. It is nothing other than human, from its very first moments. That it is "alive" is a matter that needs no special argument: If it were not alive and growing, an abortion would no more be controversial than a tonsillectomy. If the law casts its protection over human persons, the plain import

is that it casts its protection over human beings regardless of their size, their infirmities, their age or their height.[4]

Wilson's views on the subject were formed against a certain backdrop, shared by all of the leading Founders, about the nature of human rights. In his first lecture on jurisprudence at the University of Pennsylvania in 1790, for example, Wilson described that the purpose of the Constitution was not to invent new rights, but to secure those we already had by virtue of our nature as human

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[4] It has been common, we know, to insist that fetuses, or unborn children in the womb, do not really stand among the "persons" mentioned at different points in the Constitution. They were clearly not the persons "held to Service or Labor in one State, under the Laws thereof, escaping into another." U.S. Const. art. IV, § 2. The more familiar question is whether they may stand among the persons who are protected from any deprivation of "life, liberty, or property, without due process of law" under the Fourteenth Amendment—or under the Fifth. But the importance of the task exists whether we define the unborn child as a "fetus" or as a "person," for in our judgment, the debate over nomenclature has been a long-running ritual in the begging of the question. The whole purpose of assigning this nascent human to the category of fetuses rather than "persons" has been to withdraw the unborn child from the protection of the law. That is a moral judgment of deep consequence, and it cannot be affected by simply offering a change of description or a shift in labels—from a "snark," say, to a "boojum." It no more settles the moral and jural question here than it could have settled the question of slavery by renaming black people as "chattels." Something else needs to be said, something in the domain of substantive argument, to establish why these nascent human beings, these beings who cannot be anything other than human from their earliest moments, can be thrust aside, left outside the circle of other human beings covered by the protection and reach of the laws.

beings. Wilson also took for granted that all of our rights did not spring from positive law. He began, that is, with an understanding of rights that we possessed by nature, even before the formation of different governments, with different ensembles of positive law.

The same principles had been articulated 14 years earlier by Thomas Jefferson in the second paragraph of the Declaration of Independence, when he noted that human beings "are endowed by their Creator with certain unalienable rights" and then proceeded to identify the right to "Life" as first in his list of unalienable rights. In this, he followed John Locke (among others), who found the obligation within the law of nature for all men to deal honestly, to fulfill their promises, and "*not to impair the life*" or "the liberty, health, *limb* or goods of another." John Locke, TWO TREATISES OF GOVERNMENT, Book II, Ch. 2, Sec. 6 (1690) (emphasis added); *cf. Gonzales* v. *Planned Parenthood*, 435 F.3d 1163, 1167 (9th Cir. 2006) (describing the manner in which D & E abortion rips the limbs from a near-born child). The delegates to the Virginia ratifying convention echoed the theme, noting in their statement in ratification of the Constitution "[t]hat there are certain natural rights, of which men, when they form a social compact, cannot deprive or divest their posterity; among which are the *enjoyment of life* and liberty, with the means of acquiring, possessing, and protecting property, and pursuing and obtaining happiness and safety." St. George Tucker, VIEW OF THE CONSTITUTION OF THE UNITED STATES 12 (Liberty Fund 1999) (emphasis added).

One of the purposes of the Fourteenth Amendment was to secure such basic, fundamental rights against the

state governments, even if those principles were left somewhat undefined. This Court has repeatedly given voice to the same idea, finding fundamental, though unenumerated, rights in the grand pronouncements of the Fourteenth Amendment. *See, e.g.*, *Troxel* v. *Granville*, 530 U.S. 57 (2000); *Griswold* v. *Connecticut*, 381 U.S. 479 (1965); *Pierce* v. *Society of Sisters*, 268 U.S. 510 (1925); *Meyer* v. *Nebraska*, 262 U.S. 390 (1923). So unless this Court is willing to rebuke the entire body of its fundamental rights jurisprudence, we must proceed from the premise that the Fourteenth Amendment offers a foundation upon which Congress, via Section 5 of that Amendment, is on thoroughly defensible ground in enforcing fundamental respect for life at its earliest stage.

Even if one rejects the basic premise that the Fourteenth Amendment protects fundamental though unenumerated rights (including rights at issue in the abortion context), or adheres to the view that such rights remain under the realm of state authority unless expressly enumerated in the text of the Amendment, it is clear that this Court has already adopted the opposite view. One thing that is clearly untenable, however, is for the Court to have jurisdiction over a subject matter that is nevertheless closed to Congress under principles of federalism or the related doctrine of enumerated powers.

In *Cohens* v. *Virginia*, Chief Justice Marshall observed that "the judicial power of every well constituted government must be co-extensive with the legislative, and must be capable of deciding every judicial question which grows out of the constitution and laws." 19 U.S. (6 Wheat.), at 384. *See also* THE FEDERALIST NO. 80 (Alexander Hamilton) ("If there are such things as po-

litical axioms, the propriety of the judicial power of a government being coextensive with its legislative, may be ranked among the number"). That is to say, any issue that arises under the Constitution and laws of the United States, any issue arising for the federal government, had to come *presumptively* within the jurisdiction of the federal courts.[5]

The matter is indeed so axiomatic that the attempt to spell out the supporting reasoning may strike modern observers as somewhat quaint. Yet those steps were filled in at the beginning of the American law. James Wilson, in the first days of this Court, invoked Bracton's maxim, *Supervacuum esset leges condere, nisi esset qui leges tueretur*: "It would be superfluous to make laws, unless those laws, when made, were to be enforced." *Chisholm* v. *Georgia*, 2 U.S. (2 Dall.) 419, 464 (1793). Wilson went on to note that "when the laws are plain, and the application of them is uncontroverted, they are enforced immediately by the Executive authority of Government. When the application of them is doubtful or intricate, the interposition of the judicial authority becomes necessary." *Id.*, at 464-65. For most of

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[5] That reigning presumption would be dissolved, of course, when there was something in the laws, or in the structure of the Constitution itself, that explicitly withheld that jurisdiction. The appellate power of the Supreme Court is subject to "such Exceptions, and . . . such Regulations as the Congress shall make," for example. U.S. Const. art. II, § 2. And other areas of national power are explicitly and exclusively assigned to one of the coordinate branches of government. *See, e.g.*, *United States* v. *Belmont*, 301 U.S 324 (1937) (refusing to review the decision of the Executive in recognizing the Soviet Union).

us the understanding is so elementary that it no longer needs restating: If there is the authority to legislate, there must be the authority to enforce or administer what has been enacted as law. And if a constitution provides for a separation of powers, with a judicial branch, the authority to judge those laws, independently, as they bear on cases in controversy, or disputes about the meaning of those laws—those cases must come within the reach of the judiciary. *See Marbury* v. *Madison*, 5 U.S. (1 Cranch) 137, 173-74 (1803); THE FEDERALIST No. 78 (Alexander Hamilton).

But the corollary must also be true: Any issue that comes within the competence of the judicial branch must come, presumptively at least, within the reach of the legislative and executive branches as well. If the Court can articulate new rights under the Constitution—as in a right to abortion—the legislative branch must have the authority to legislate regarding those same rights on precisely the same ground established by the courts as the constitutional ground of those rights.

After meandering through the penumbral emanations of various constitutional provisions, this Court itself seems to have come to rest on the Fourteenth Amendment as the source of the fundamental right to a mother's privacy and bodily autonomy (which, in the Court's view, leads inexorably to the right to abortion) as well as to an unborn child's right to life (at least that of a post-viability unborn child). *See, e.g., Planned Parenthood* v. *Casey*, 505 U.S. 833, 876 (1992). Since the Court has found a right to abortion in the Fourteenth Amendment, then Congress must have the authority to protect and fill out that same right under the Fourteenth

Amendment. Similarly, since the Court has recognized in the Fourteenth Amendment a state's substantial interest in protecting a pre-born's right to life, then Congress must likewise have the authority to protect and fill out that same right, and to adopt legislative solutions to the inevitable conflicts between the two.

While, in the natural law/common law tradition,[6] the recognition of new, unenumerated rights may be part of the judicial prerogative, an unelected judiciary cannot be the sole voice in such matters, at least not if ours is to continue to be a government grounded in the consent of the governed. The scope of new-found unenumerated rights, and the weight to be given them when they come in conflict with other fundamental rights, is more properly a legislative than a judicial function.[7]

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[6] We equate the common law with the natural law, in accord with the understanding at the time of the founding. See, e.g., Letter from Jeremiah Hill to George Thatcher (Jan. 9, 1788), *reprinted in* 5 Documentary History of the Ratification of the Constitution 659 (describing a Bill of Rights as "no more than a Collection of Sentences from the Common Law, which sprang from the Law of nature, collected and compiled together from the experience of former Ages").

[7] We are not here dealing with a congressional attempt to redefine an explicit textual requirement of the Constitution, *cf. City of Boerne v. Flores*, 521 U.S. 507 (1997). Rather, we are dealing with non-textual requirements of the Constitution, necessarily looking to a higher authority than the actual text has provided as a matter of positive law. It is simply inconceivable to think that the Court has not only the power to invent new rights under this claimed authority, but the exclusive power to define the scope and weight to be given to those rights, even against legislative judgments to the contrary.

Congress, could also fill out legislatively such rights even more fully than a court, for a court would ever be operating within the constraints of cases confined, as they are, to the interests in conflict between two litigants. *See Muskrat* v. *United States*, 219 U.S. 346, 356 (1911). And it must also have the legislative power to define the limits on those rights, and to weigh those rights against others at least as fundamental. The one thing that is untenable, under the logic of this Constitution and the separation of powers, would be for the Court to articulate new rights—and then assign to itself a monopoly of the legislative power in shaping those rights. Such would be "the very definition of tyranny." THE FEDERALIST No. 47 (James Madison). It "would place us under the despotism of an oligarchy." Letter from Thomas Jefferson to William Charles Jarvis (Sept. 28, 1820) *in* 15 The Writings of Thomas Jefferson 276, 277 (Andrew A. Lipscomb & Albert Ellery Bergh eds., 1904).

Abraham Lincoln, criticizing this Court's decision in *Dred Scott* v. *Sandford*, 60 U.S. (19 How.) 393 (1856), made a similar point in his First Inaugural Address:

> [T]he candid citizen must confess that if the policy of the government, upon vital questions, affecting the whole people, is to be irrevocably fixed by decision of the Supreme Court, . . . the people will have ceased, to be their own rulers, having, to that extent, practically resigned their government, into the hands of that eminent tribunal.

Abraham Lincoln, First Inaugural Address—Final Text (Mar. 4, 1861), *in* 4 THE COLLECTED WORKS OF ABRAHAM LINCOLN 262, 268 (Roy P. Basler ed., 1953).

The notion that the legislature would have a hand (indeed, the principal hand) in shaping the scope of newly-discovered unenumerated rights is not new; indeed, it is, in a related context, an explicit part of the Constitution. Article I, Section 8, Clause 10 gives to Congress the power "To define and punish . . . Offences against the Law of Nations." Those who drafted and ratified the Constitution understood the "Law of Nations" to be "the law of nature applied to states and sovereigns, obligatory upon them in the same manner, and for the same reasons, as the law of nature is obligatory upon individuals." JAMES WILSON, 1 THE WORKS OF JAMES WILSON 148-67 (Robert Green McCloskey ed., 1967) (1791); *see also, e.g.,* JAMES KENT, 1 COMMENTARIES ON AMERICAN LAW 1-4 (1826) ("[the] application of the law of nature has been called by Vattel, the necessary law of nations, because nations are bound by the law of nature to observe it"); *cf.* HUGO GROTIUS, DE JURE BELLI AC PACIS, bk. I, ch. I, § XIV (A.C. Campbell, trans., London, 1814) ("scarce any right can be found common to all nations, except the law of nature, which itself too is generally called the law of nations"); EMANUAL VATTEL, THE LAW OF NATIONS OR THE PRINCIPLES OF THE NATURAL LAW, Preliminaries § 6 (1758) ("the law of Nations is originally no other than the law of Nature applied to Nations").

Some of those laws were of long-standing acceptance, and they were binding upon the United States (just as the laws of nature are binding upon individuals) even apart from positive-law proscriptions. *See, e.g.,*

Kent, at 1-4 ("The law of nations, so far as it is founded on the principles of natural law, is equally binding in every age, and upon all mankind"). But, out of recognition that our understanding of the immutable principles of the laws of nature and of nations becomes more fully developed over time, the Constitution explicitly assigns the power to "define" offences against the Law of Nations to Congress. *See, e.g.*, JOSEPH STORY, COMMENTARIES ON THE CONSTITUTION OF THE UNITED STATES § 1158 (1833) ("Offences against the law of nations . . . cannot with any accuracy be said to be completely ascertained, and defined in any public code . . . . In respect, therefore, . . . to offences against the law of nations, there is a peculiar fitness in giving to congress the power to define, as well as to punish"); MAX FARRAND, ED., 2 RECORDS OF THE FEDERAL CONVENTION 614-15 (Sept. 14, 1787) (exchange between James Wilson and Gouvernor Morris, in which Morris argues that the power to "define" is necessary because of the vagueness of the Law of Nations).

The analogy to domestic unenumerated rights should be obvious. While it is certainly within the power of the courts to enforce rights explicitly enumerated in the text of a written constitution (and even to do so over the objection of legislative majorities, in order to protect individual and minority rights, *see United States* v. *Carolene Products*, 304 U.S. 144, 152 n. 4 (1938), the authority of the judiciary must necessarily be more circumspect when it ventures to "define" new, unenumerated rights, affording to the legislature (and through it, the sovereign people) a much greater role to play in describing the extent of the right, and even whether the "right" should properly be deemed a right at all! To do

otherwise would be to substitute "the despotism of an oligarchy" for the government by consent of the governed mandated by the principles of the Declaration and given effect by the Constitution.

John Locke, whose influence on the Founders is well-known, pierced to the logical core of the separation of powers when he noted the discipline that would have to bear on legislators:

> [I]n well-ordered commonwealths, where the good of the whole is so considered as it ought, the legislative power is put into the hands of divers persons who, . . . have by themselves, or jointly with others, a power to make laws, which when they have done, being separated again, they are themselves subject to the law they have made; which is a new and near tie upon them to take care that they make them for the public good.

JOHN LOCKE, TWO TREATISE OF GOVERNMENT, Sec. 143 (1690). In this manner, the separation of powers would contain the logic of the Categorical Imperative or what the philosophers would call the "universalizability principle." *See* IMMANUEL KANT, GROUNDWORK OF THE METAPHYSIC OF MORALS (H. J. Paton, trans., 1956). Legislators would be cautioned that the laws they frame must be placed, for their administration, in hands other than their own, and those could well be the hands of their political adversaries. The legislators had better take care, then, not to legislate for others the kind of measures that they would not readily see enforced against themselves as well.

We do not see how the courts can be exempted from the same logic. Perhaps this Court may articulate new rights, or draw out of the Constitution implications previously unseen; but if it has done that, it cannot control completely what a legislature may do in filling out, in more detail, across a broader range, the constitutional rights that the Court itself has brought to the level of recognition. *See* THE FEDERALIST NO. 47, at 300 (James Madison) (quoting Montesquieu: "Were the power of judging joined with the legislative, the life and liberty of the subject would be exposed to arbitrary control, for the *judge* would be the *legislator*").

An example of this Court's encroaching into the legislative arena, with disastrous consequences, is illustrated in the infamous *Dred Scott* case. *Scott v. Sandford*, 60 U.S. 393 (1857). The late Chief Justice Rehnquist wrote that the Court disregarded all of Congress's debate and legislation in the Missouri Compromise, the Wilmot Proviso, and the Kansas-Nebraska Act and then asserted "that the [slavery] decision had never been one that Congress was entitled to make, because it was one that the Court alone, in construing the Constitution, was empowered to make." William Rehnquist, "The Notion of a Living Constitution," 29 HARV. J.L. & PUB. POL'Y 401, 410 (2006). In fact, the Court asserted that the right to property in a slave was to be afforded the same protection as all other property rights. *Scott*, 60 U.S., at 452. The Court granted itself a monopoly over shaping this right and as Chief Justice Rehnquist pointed out, under the Court's erroneous view, "Congress was without power to legislate upon the issue of slavery even in a territory governed by it" and was "virtually powerless to check or limit the spread of the insti-

tution of slavery." Rehnquist, 29 HARV. J. L. & PUB. POL'Y, at 410. We must not make the same mistake again. As noted above, Lincoln thankfully refused to allow the question of slavery to "be irrevocably fixed by decision of the Supreme Court," lest the people cease "to be their own rulers, having, to that extent, practically resigned their government, into the hands of that eminent tribunal." Abraham Lincoln, First Inaugural Address (1861). The principle of government by consent of the governed requires no less here.

III. The Right to Abortion Articulated by this Court Does Not Bar Congress's Efforts to Mark the Limits of the Right or to Protect Other Fundamental Rights.

What Congress has done, by enacting the Partial-Birth Abortion Ban Act of 2003, is quite in accord with the authority that the legislative branch may rightly exercise in drawing out more precisely the implications of the rights articulated by the courts. For in filling out those rights, the legislative branch may also mark their limits. In this instance, Congress is positing this judgment: that whatever else a right to abortion encompasses, it could not have been meant to entail a right to destroy a child at the very point of birth, and with methods so patently cruel and painful. Nothing in *Roe v. Wade*, 410 U.S. 113 (1973), or the companion case of *Doe v. Bolton*, 410 U.S. 179 (1973), ever staked out explicitly such a claim. Nor is it apparent that this Court would find such a right entailed by its decision in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992)—a right to perform abortions right up and through the time of birth, on a child partially removed from the birth ca-

nal. Indeed, during re-argument in *Roe v. Wade,* Justice Marshall stated that killing of a child in the process of childbirth "is not an abortion," to which Petitioner (counsel for Jane Roe) responded, "You're correct, sir. It would be homicide." Transcript of Oral Reargument, *Roe* v. *Wade*, 410 U.S. 113 (1973) (available at http://www.oyez.org/oyez/resource/case/334/reargument/transcript) (last visited Aug. 2, 2006).

Nor would it flow, from the previous holdings of the Court, that abortions may not be restricted in their methods. As this Court has recognized, a right to abortion would not be impaired merely because certain restrictions were imposed to safeguard the health of the pregnant woman (e.g., by insisting that the abortions be performed in hospitals or licensed clinics). *See Roe*, 410 U.S., at 163. Nor would that right be impaired if the legislature imposed restraints inspired by a concern for the treatment of the unborn child. *See Webster v. Reproductive Health Services*, 492 U.S. 490, 519 (1989).[8] Even if Congress had no responsibility of its own to judge the constitutionality of the measures it is enacting—even if it had no standing as a branch of the

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[8] As Chief Justice Rehnquist observed there, "we do not see why the State's interest in protecting potential human life should come into existence only at the point of viability." The Chief Justice would cite in that vein Justices O'Connor and White dissenting in *Thornburgh* v. *American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986). *See id.*, at 795 (White, J., dissenting) ("[T]he State's interest, if compelling after viability, is equally compelling before viability"); *id.*, at 828 (O'Connor, J., dissenting) ("[The] State has compelling interests in ensuring maternal health and in protecting potential human life, and these interests exist throughout pregnancy").

government on a plane of dignity comparable to that of this Court—it would still be reasonable for Congress to put forth this understanding, to propose, in effect, to the Court that this measure is quite consistent with the rights that the Court had articulated in *Roe v. Wade*.

Under the principles articulated above, Congress also has the authority to do more than merely marking the outer limit of the right to abortion. Congress would be on thoroughly defensible ground in acting for the sake of protecting the life within the womb. For that, of course, there is no need to make a finding about the "human" standing of the offspring. Congress has flexed its authority in other instances to protect endangered species and other animals. A Congress that can protect tuna and whales and snail darters is not confined, in its moral concerns, to every vulnerable animal *apart from humans*. As the example of other animals makes abundantly clear, there is no need to qualify as a "person" in order to come with the protection of the laws and the power of Congress. As the late Judge Friendly correctly noted in a pre-*Roe* draft opinion that was never issued when the particular case became moot, even if the legislature is not compelled to "extend to the fetus the same protection against destruction that it does after birth, it would be incongruous...for us to hold that a legislature went beyond constitutional bounds in protecting the fetus." *See* A. Raymond Randolph, *Address: Before Roe v. Wade: Judge Friendly's Draft Abortion Opinion*, 29 HARV. J.L. & PUB. POL'Y 1035, 1040 (2006).

This Court has explored the boundaries of privacy and dignity to find rights previously undescribed. A woman's right to privacy now supplants the potential to

afford a formative human life the same level of dignity now accorded animals and the least deserving among us, from convicted criminals to unlawful combatants. The criminal is protected from torture or an unnecessarily painful execution because, notwithstanding his offense, he is still entitled to a minimum standard of dignity.[9] Death row convicts rate the concern that the methods of execution are administered without any "wanton infliction of pain." *Gregg* v. *Georgia*, 428 U.S. 153, 173 (1976) (opinion of Stewart, Powell, and STEVENS, JJ.). This Court has admonished the military to be mindful of the dignity of those considered enemy combatants in the current War on Terror. See *Hamden* v. *Rumsfeld*, 1260 S. Ct. 2749 (2006); *Hamdi* v. *Rumsfeld*, 542 U.S. 507 (2004). We even cloak methods to end life when continuing to live would be painful or complicated as "death with dignity." *See Washington* v. *Glucksberg*, 521 U.S. 702 (1997).

Among the hierarchy of those deserving dignity protections, we must find a place for the innocent and worthy unborn human life, even against claims of privacy. Common law recognized, for example, that the right to privacy had to yield to protect the life and dignity of the unborn. The Writ *de Ventre Inspiciendo* required that a

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[9] In one case, the Court stated that the acts of beheading or quartering a criminal would constitute cruel and unusual punishment. *Wilkerson* v. *Utah*, 99 U.S. 130, 135 (1879). Under the same reasoning, Congress has every right to protect an unborn child from "the pain associated with piercing his or her skull and sucking out his or her brain," or from having his or her body severed as his limbs are torn off. *See* The Partial-Birth Abortion Ban Act of 2003, § 2(14)(M), 117 Stat. 1201, 1205; *Stenberg* v. *Carhart*, 530 U.S. 914, 958-59 (2000).

woman convicted of a capital crime relinquish her right of privacy and undergo an invasive physical exam to determine if she was pregnant. The unborn child was thus afforded protection apart from the punishment required by the mother's crime. *Union Pacific Railway v. Botsford*, 141 U.S. 250, 253 (1891); Black' Law Dictionary 452 (6th ed. 1990) (citing 4 WILLIAM BLACKSTONE, COMMENTARIES 395 (1769)).

While we take great care that "broad and idealistic concepts of dignity, civilized standards, humanity, and decency," are encompassed in adhering to the Eighth Amendment protections against cruel and unusual punishment, *Victoria W.* v. *Larpenter*, 369 F.3d 475, 483 (5th Cir. 2004), there must be an effort within these vaunted concepts of dignity, humanity, and decency to protect an innocent, unborn child from the barbarism of a late-term abortion.

It should be noted that Congress has not here claimed the authority to overturn any judgment rendered in a case by the courts. But for the reasons set out above, Congress commands ample authority to frame general policies in the field engaged by the Court, and to reach judgments not entirely identical to the judgments that the Court might reach. The Court declared in *Dred Scott* that blacks could not be citizens of the United States. But to say that Dred Scott was not a citizen did not bar the Congress, or the President, from respecting the citizenship of other black people in other domains. *See* HADLEY ARKES, FIRST THINGS 419-21 (1986) (discussing the Lincoln Administration's respect of the claim of blacks to be regarded as citizens, to carry pass-

ports of the United States abroad, and to hold patents under the laws of the United States).

Nor is there any need to overturn the decision in *Roe v. Wade* in order to sustain that Act at issue here, and Congress has not risen to that level of confrontation in this instance. Congress has offered what might be seen as the gentlest act in countering the sweep of the "abortion liberty." It has sought to find the most evident, plausible limit to that right to abortion, a limit that has commanded the assent of the broad public. And now, in effect, Congress proposes that limit to the courts, with a reasonable hope to command the assent of our jurists as well. Our own judgment, deepened by our own hope, is that this Court will accept this gentle offer to enter into a conversation on the contours of the right to abortion it has unilaterally recognized. And our plea then is to sustain this measure, so carefully considered and passed in three Congresses.

CONCLUSION

The decision of the Ninth Circuit should be reversed, and the Partial-Birth Abortion Ban Act of 2003 upheld.

Respectfully submitted,

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In The

Supreme Court of the United States

Alberto Gonzales,

Petitioner,

v.

Planned Parenthood Federation of America *et al.*,

Respondents.

On Writ of Certiorari
to the United States Court of Appeals
for the Ninth Circuit

BRIEF OF *AMICUS CURIAE* CALIFORNIA MEDICAL ASSOCIATION IN SUPPORT OF RESPONDENTS

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QUESTION PRESENTED

Does Congress' use of the phrase "in or affecting interstate or foreign commerce" in 18 U.S.C. 1531(a), to describe those abortions that it seeks to criminalize, provide physicians who are considering performing an abortion constitutionally adequate notice under the due process clause of which abortions are covered by that provision?

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STATEMENT OF INTEREST[1]

The California Medical Association ("CMA") – California's largest medical association with more than 30,000 members – exists to promote the science and art of medicine, the care and well-being of patients, the protection of public health, and the betterment of the medical profession. CMA opposes the "Partial Birth Abortion Ban Act of 2003" ("PABA" or the "Act"), which lacks foundation in medical science, endangers the health of women throughout California, disrupts the physician-patient relationship, and makes criminals of highly trained physicians when they perform the safest and most common procedures available for second-trimester abortions.

CMA filed an *amicus* brief (with others) in the Ninth Circuit urging that the Act be declared unconstitutional. That brief argued that the Act is an unwarranted intrusion on the doctor-patient relationship, that it prevents physicians from carrying out their duty to protect the health and lives of their patients, and that the Act's requirements are unconstitutionally vague and therefore they unduly burden protected reproductive choice. CMA agrees with the briefs to be filed by respondents in this case and in the related case of *Gonzales* v. *Carhart*, No. 05-380, and by the *amici* supporting them, that the Act is unconstitutional for all the reasons urged by CMA in the court of appeals.

This brief is being filed to focus on an issue that is not as fully developed in other briefs and has a particular salience to CMA. Until the passage of the Act, abortions were regulated at the state level, and under California law CMA's members

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[1] The parties have consented to the filing of this brief. Their letters of consent have been filed with the Clerk of this Court. Pursuant to this Court's Rule 37.6, *amicus* states that none of the parties or their counsel wrote the brief in whole or in part and that no one other than *amicus* and its counsel made any monetary contribution to the preparation or submission of the brief.

who perform abortions were able to choose among medically accepted procedures solely on the basis of their patients' welfare. But the Act changes all that by mandating a uniform federal criminal law banning what the Act calls partial birth abortions, even though they are legal under the laws of California, on the theory that the abortions covered by the Act should be regulated under the commerce clause. To carry out this unwarranted intrusion into what has previously been an area of state regulation, the Act makes only abortions "in or affecting interstate or foreign commerce" subject to its ban. But as this brief shows, that phrase is so vague in describing which abortions satisfy the commerce clause nexus that no physician, and quite possibly no lawyer or constitutional scholar, can know whether performing such an abortion will subject the doctor to criminal and civil liability. Because the Act will place members of CMA at personal risk, its vagueness may affect the exercise of their medical judgment, creating an incentive for them to choose a medical procedure that might be less legally risky for them, but less safe for their patients, precisely the kind of undue burden on reproductive choice that this Court has repeatedly condemned.

INTRODUCTION AND SUMMARY OF ARGUMENT

Abortion is an issue on which Americans are deeply divided. The result, in our federal system, has been that states – within the constitutional boundaries set by the due process clause of the Fourteenth Amendment – have taken dramatically different approaches. Some states have regulated or restricted access to abortion in every way that the Constitution permits. Other states, like California, have consciously refused to impose such limits, and have even chosen to subsidize the ability of women to obtain abortions. Of particular salience to this case, some states have declined to forbid the abortions arguably covered by section 1531, and have instead left to physicians and their patients decisions regarding which abortion procedure will be the safest and most appropriate given the patient's particular circumstances.

The Act before the Court in this case marks an unprecedented attempt by Congress to impose a national standard, purely as a policy matter and on the basis of highly contested and contestable factual "findings," on the choice among abortion procedures. From the text of the statute, it is clear that Congress grounds its authority to impose a national standard – to the exclusion of the individual states' judgments about how to regulate medical practice – on its authority under the commerce clause. For reasons set out in the briefs of respondents and other *amici curiae* supporting respondents, we believe that the Act runs afoul of the substantive liberty protected by the due process clause of the Fifth Amendment.

Not only does the Act implicate the limitations on any government's right to restrict access to abortions contained in the due process clauses (here, of the Fifth Amendment), but it also raises the question whether the Act would otherwise reflect a permissible exercise of one of Congress' enumerated powers. *Amicus* believes that it does not. Despite its ostensible invocation of Congress' commerce clause powers, the Act in fact fails to provide constitutionally adequate notice to the physicians whom it purports to regulate as to which abortions fall within its scope. This failure arises not only for the reasons set out by the court of appeals below, see *Planned Parenthood Fed'n* v. *Gonzales*, 435 F.3d 1163, 1183-85 (CA9 2006), and foreshadowed by this Court's decision in *Stenberg* v. *Carhart*, 530 U.S. 914 (2000), but also because of its imprecision with respect to whether a particular abortion is performed "in or affecting interstate or foreign commerce."[2] This vagueness is especially problematic in light of the serious federalism concerns implicated by Congress' decision to forbid the abortions covered by the Act, despite many states' best judgment that those abortions are appropriate in circumstances where the

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[2] For the sake of convenience, we omit further references to "foreign" commerce.

physician concludes that the procedure is necessary to protect the health and welfare of his or her patient.

One fundamental problem with the statute that Congress passed is that its jurisdictional element is so vague that no physician can know whether he or she is violating the law because there is no guidance, and no regulatory agency to provide it, on which abortions do and do not fall within the statute. Moreover, because the Act imposes serious penalties on physicians – imprisonment for up to two years, a fine of up to $250,000, or both – uncertainty about its scope is likely to have a substantial harmful effect on the constitutional rights of the women whom those physicians serve. To avoid prosecution, physicians may decline to use the abortion procedure indicated by their best medical judgments – either refusing to perform an abortion at all or choosing the method that best protects them, rather than their patients.

Finally, this statute implicates the federalism concerns that underlie this Court's recognition that Congress' commerce power is not unlimited. Health and safety laws, including those regulating the medical profession and the performance of abortions, have historically been the province of the States, not Congress, and yet the Act preempts every State law that reaches a different conclusion about the propriety of particular abortion techniques, with no showing that this is an issue requiring a single national answer.

ARGUMENT

I. Because Its Jurisdictional Element Fails to Define Clearly Which Abortions Are Prohibited, Section 1531 Is Not a Permissible Exercise of the Commerce Power.

The statute at issue in this case, 18 U.S.C. 1531, makes it a federal crime for a physician to perform certain abortions,

even if their performance would be permitted by state law.[3] As this Court observed in *United States* v. *Lopez*, 514 U.S. 549, 561 n.3 (1995), "[w]hen Congress criminalizes conduct already denounced as criminal by the States, it effects a change in the sensitive relation between federal and state criminal jurisdiction" (internal quotation marks omitted). *A fortiori*, when Congress "displace[s] state policy choices in . . . that its prohibitions apply even in States that have chosen not to outlaw the conduct in question," *ibid.* (internal quotation marks omitted), that shift is even greater.

It is undisputed after *Lopez* that "limitations on the commerce power are inherent in the very language of the Commerce Clause." 514 U.S. at 553. Thus, if the Court were simply to assume that the commerce clause was properly invoked in a given statute, it would require the Court "to conclude that the Constitution's enumeration of powers does not presuppose something not enumerated" and that there can "never . . . be a distinction between what is truly national and what is truly local." *Id.* at 567-68.

A. Section 1531 Relies on a Commerce Clause-Based Jurisdictional Element to Describe the Class of Abortions Congress Is Purporting to Restrict.

In recognition of *Lopez*, Congress limited the scope of PABA's criminal prohibition in two ways. First, the statute contains a definitional provision – section 1531(b)(1) – that purports to outlaw only some abortions. The attempt to narrow the category of forbidden abortions is constitutionally

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[3] The statute also makes the physician potentially liable in a damages action by the patient's husband or her parents, if she is a minor. 18 U.S.C. 1531(c). The prospect of civil liability creates a further, substantial chilling effect, because physicians may face costly civil suits in situations where prosecutors would decline to charge them, or juries would decline to convict them, because all the elements of a section 1531 violation could not be proven beyond a reasonable doubt.

infirm for the reasons set out by the courts of appeals in this case, see *Planned Parenthood Fed'n* v. *Gonzales*, 435 F.3d 1163, 1182-85 (CA9 2006), and the Eighth Circuit in *Carhart* v. *Gonzales*, 413 F.3d 791, 797-804 (2005) (cert. granted, Feb. 21, 2006), and foreshadowed by this Court's decision in *Stenberg* v. *Carhart*, 530 U.S. 914 (2000). We will not further address those issues here.

Second, the statute contains a "jurisdictional element" in section 1531(a) that imposes criminal liability only on "[a]ny physician who, in or affecting interstate or foreign commerce, knowingly performs" the specified procedure. Congress quite clearly included the jurisdictional element in response to this Court's decision in *Lopez*. There, this Court held that Congress had exceeded its commerce power in enacting a provision that made it a federal offense for any individual knowingly to possess a firearm within a school zone. 18 U.S.C. 922(q)(2)(A). One of the infirmities that the Court identified was the statute's failure to contain a "jurisdictional element which would ensure, through case-by-case inquiry," that the charged violation "affects interstate commerce." *Lopez*, 514 U.S. at 561.

Section 1531 has been challenged on the ground that it violates the substantive liberty protected by the due process clause of the Fifth Amendment. But this Court need reach that question only if it first concludes that the statute would otherwise represent a permissible use of one of Congress' enumerated powers.

The jurisdictional element and legislative history of section 1531 both reveal that Congress has relied entirely on its commerce power in enacting PABA. *Amicus* has no quarrel with the underlying factual premise that providing abortion services can have effects on interstate commerce and that the commerce power can be used in some circumstances to impose federal regulation on them. The Freedom of Access to Clinic Entrances Act (FACE), 18 U.S.C. 248(a)(1), (3), for example, prohibits interference with individuals who are seeking to obtain or provide reproductive health services,

(or facilities providing such services) including abortions. The courts of appeals have unanimously upheld FACE as within Congress' power to regulate "activities that substantially affect interstate commerce." See, *e.g.*, *Hoffman* v. *Hunt*, 126 F.3d 575, 582-88 (CA4 1997), cert. denied, 523 U.S. 1136 (1998); *United States* v. *Wilson*, 73 F.3d 675, 680-84 (CA7 1995), cert. denied, 519 U.S. 806 (1996); *Cheffer* v. *Reno*, 55 F.3d 1517, 1519-21 (CA11 1995).

Congress has not, however, chosen to regulate abortions generally in PABA. Nor has Congress concluded that the subset of all abortions that it has sought to regulate invariably affects interstate commerce. Thus, PABA is quite unlike the comprehensive scheme for regulating marijuana at issue in *Gonzales* v. *Raich*, 125 S. Ct. 2195 (2005), which this Court upheld even when it extended to its intrastate, noncommercial cultivation, possession, and use.

Instead, Congress has ostensibly chosen to criminalize only some abortions, and then on a case-by-case basis, where the particular abortion in question is "in or affecting interstate commerce." While the jurisdictional element addresses one potential constitutional difficulty, it creates other constitutional difficulties under the due process clause because it fails to give adequate notice of the line between criminal and non-criminal conduct.

The jurisdictional element appears expressly within section 1531(a) itself and thus is an element of the criminal offense: Prosecutors must prove, beyond a reasonable doubt, in every prosecution, that the physician who performed the abortion was "in or affecting . . . interstate commerce." See *Russell* v. *United States*, 471 U.S. 858, 862 (1985) (recognizing that use of a building had to be in or affecting commerce to prove a violation under the federal arson statute, 18 U.S.C. 844(i));[4] *United States* v. *Bass*, 404 U.S. 336, 347

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[4] In *Jones* v. *United States*, 529 U.S. 848 (2000), this Court unanimously construed the federal arson statute not to reach the destruction of purely residential property. The Court noted that the

(1971) (holding that the government must show a nexus to interstate commerce to prove felon-in-possession-of-handgun offense under 18 U.S.C. App. 1202(a)). Congress clearly understood that it was imposing such a requirement: the House Report accompanying PABA quoted *Lopez*:

> H.R. 760 also contains a jurisdictional requirement, "[a]ny physician who, in or affecting interstate or foreign commerce, knowingly performs a partial-birth abortion . . . ," which will "ensure, through case-by-case inquiry, that" *the partial-birth abortion "in question affects interstate commerce*."

H.R. Rep. No. 108-58, at 26 (2003) (emphasis added). Thus, Congress expressly declined to presume that *every* abortion that fits within section 1531(b)(1) *also* satisfies section 1531(a)'s jurisdictional element: if it did, there would be no need for a "case-by-case inquiry." Indeed, to read section 1531(a) as proscribing all the abortions described in section 1531(b)(1) would render the jurisdictional element superfluous, violating the "cardinal principle of statutory construction that a statute ought, upon the whole, to be so construed that, if it can be prevented, no clause, sentence, or

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statute "required that the damaged or destroyed property *must itself* have been used in commerce or in an activity affecting commerce," rather than simply that the building's destruction "might affect interstate commerce." *Id.* at 854 (emphasis added; internal quotation marks omitted). While the Court recognized that it would be *possible* to read the statute more broadly, it reiterated that "when choice must be made between two readings of what conduct Congress has made a crime, it is appropriate, before choosing the harsher alternative, to require that Congress should have spoken in language that is clear and definite." *Id.* at 858.

The same considerations obtain here. Congress provided that the specific abortion that a physician performed must *itself* have a substantial effect on interstate commerce, rather than presuming that all abortions are covered.

word shall be superfluous, void, or insignificant." *TRW Inc.* v. *Andrews*, 534 U.S. 19, 31 (2001) (citations and internal quotations omitted); see also *Ratzlaf* v. *United States*, 510 U.S. 135, 140-41 (1994) (explaining that resistance to treating statutory terms as surplusage "should be heightened when the words describe an element of a criminal offense").

B. Section 1531 Fails to Provide Constitutionally Sufficient Notice as to Which Abortions Fall Within the Statute.

Having enacted a statute that requires that the "abortion in question affects interstate commerce," H.R. Rep., *supra*, Congress provided no guidance as to which facts would be relevant to that inquiry. Although PABA contains lengthy "findings" that set out what it claims to be the "moral, medical, and ethical consensus" surrounding the abortions it sought to outlaw, and that address at length the case law regarding judicial deference given to prior examples of congressional factfinding, the text of the law notably omitted *any* factual findings with regard to the effects on interstate commerce of the subset of abortions that it sought to ban. See, *e.g.*, *Perez* v. *United States*, 402 U.S. 146, 147 n.1, 156 (1971) (noting that the federal loan-sharking statute upheld there as a permissible use of the commerce power contained detailed, formal congressional findings regarding the effects on interstate commerce).

In one sense, all abortions involve commercial activity because there will always be some goods or services that must be purchased in order to perform the abortion. Some of these goods and services may be obtained from outside the state where the abortion is performed, and thus if the Act purported to regulate all abortions on the ground that the provision of abortion services as a whole had a substantial effect on interstate commerce, that would raise a different question regarding Congress' reliance on the commerce clause. But that is not the scheme that Congress has created, both because the Act covers only some abortions and because it requires a

determination, on a case-by-case basis, that the abortion in question be one that is "in or affecting interstate commerce."

The problem is that section 1531(a) imposes criminal liability on individual physicians, but provides no guidance to physicians to enable them to conduct a case-by-case inquiry to distinguish between those abortions that are performed "in or affecting interstate commerce" and those that are not. For example, PABA does not expressly limit its coverage only to abortions performed on women who have traveled across state lines to obtain them or by doctors who have traveled across state lines to perform them. Cf. 18 U.S.C. 2261(a)(1) (making it a crime to "travel in interstate commerce" to commit domestic violence); compare Allan Ides, *The Partial-Birth Abortion Ban Act of 2003 and the Commerce Clause*, 20 Const. Comment. 441, 458 (2004) (questioning whether a patient traveling interstate is sufficient to fulfill the jurisdictional requirement), with Robert J. Pushaw, *Does Congress Have the Constitutional Power to Prohibit Partial-Birth Abortion?*, 42 Harv. J. on Legis. 319, 351 (2005) (an abortion may be "in" interstate commerce if either the doctor or patient traveled out-of-state for the abortion).[5]

Nor does PABA apply only to abortions in which the performing physician uses particular surgical instruments or medical supplies that have traveled in interstate commerce.

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[5] While Congress used the boilerplate language "in or affecting interstate commerce," it is clear that this case is really about only abortions that "affect" interstate commerce. An abortion performed on a mode of transportation traveling in interstate commerce would fall squarely within the "in commerce" portion of the Act, and a physician who performed such an abortion would have reasonable notice that his conduct met the jurisdictional prerequisite. But the likelihood that any of the abortions that Congress sought to ban would be done in such circumstances approaches zero, and hence the Act can be upheld only on a theory that the prohibited abortions have a substantial effect on interstate commerce.

Cf. 18 U.S.C. 842(i) (making it a crime for certain persons to possess "any explosive which has been shipped or transported in or affecting interstate or foreign commerce"). Thus, nothing in the text (or, indeed, the legislative history) answers the question whether a doctor who performs an abortion on a woman who lives in the state where he practices has acted "in or affecting interstate commerce" by performing that single medical procedure.[6]

Moreover, given the grammatical structure of section 1531(a), it is unclear whether whatever scienter requirement the statute contains even applies to the jurisdictional element, thereby threatening to expose physicians to federal criminal liability even if they do not know whether a particular abortion affects interstate commerce. The word "knowingly" appears after the jurisdictional phrase, immediately adjacent to the word "performs." This suggests that knowledge is required, at most, with respect to whether abortions fall within the definitional provision of section 1531(b), but not with respect to whether a particular abortion occurs in or affecting interstate commerce. In *United States* v. *Yermian*, 468 U.S. 63, 68-69 (1984), and *United States* v. *Feola*, 420 U.S. 671, 676-77 n.9 (1975), for example, this Court held that

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[6] To be sure, the House Judiciary Committee Report accompanying the Act explained the factual basis for its conclusion that the Act properly relied on the commerce clause (pp 31-36). But those facts do not appear among the multiple "findings" contained within the Act itself to which petitioner asks this Court to defer, and none of the findings relates in any way to the interstate commerce aspects of the abortions that the Act criminalizes. Even when Congress has included "findings" in support of its assertion of its commerce clause powers within legislation passed by both Houses and signed by the President, this Court has rejected them when it has concluded that the connection is too attenuated. See *United States* v. *Morrison*, 529 U.S. 598, 614 (2000).

"the existence of the fact that confers federal jurisdiction need not be one in the mind of the actor at the time he perpetrates the act made criminal by the federal statute." But in *United States* v. *X-Citement Videos*, 513 U.S. 64 (1994), the Court read a statute criminalizing the acts of "any person who . . . knowingly transports or ships in interstate commerce . . . any visual depiction, if . . . the producing of such visual depiction involves the use of a minor engaged in sexually explicit conduct," 18 U.S.C. 2252, to require proof of knowledge that the person depicted was a minor. 513 U.S. at 72 n.3. The Court expressed concern that otherwise the statute would criminalize behavior that a defendant could legitimately believe to be constitutionally protected. *See id.* at 72-78. The same is true here with respect to many physicians who perform the abortions Congress sought to outlaw: absent the "jurisdictional element" of "in or affecting . . . interstate commerce," their use of appropriate medical judgment to perform abortions legal under state law would be no offense at all.

C. The Jurisdictional Element of Section 1531 Suffers From Additional Problems With Vagueness.

The inherent problems with section 1531(a)'s jurisdictional element are exacerbated by the absence of any mechanism for seeking clarification prior to acting. In contrast, for example, to the Clean Water Act provision at issue last term in *Rapanos* v. *United States*, 126 S. Ct. 2208 (2006), there is no federal regulatory agency charged with the responsibility for issuing rules that limit the transactions that fall within the Act. See *id.* at 2235-36 (2006) (Roberts, C.J., concurring); *id.* at 2249 (Kennedy, J., concurring) ("Absent more specific regulations, however, the Corps must establish a significant nexus on case-by-case basis when it seeks to regulate wetlands based on adjacency to nonnavigable tributaries.").

Although the language and structure of section 1531 clearly contemplate a distinction between physicians acting "in or affecting interstate . . . commerce" and those who do not, neither the Act nor any federal regulatory official provides any guidance to a physician who seeks to determine into which category each abortion he contemplates performing falls. Moreover, unlike other statutes, this inquiry is not a one-time analysis for which physicians or hospitals could call on their lawyers to assist them in making the constitutional judgment. Rather, physicians must determine with regard to each procedure performed whether the performance will be in or affecting interstate commerce, often in circumstances in which the health, and perhaps the life, of the patient may be at stake. Forcing physicians to make such a choice, with all its attending uncertainties, is precisely the kind of federal interference with the physician-patient relationship that caused *amicus* to present the issues raised in this brief.

In *City of Chicago* v. *Morales*, 527 U.S. 41, 56 (1999), this Court noted that a criminal statute is unconstitutionally vague when it fails "to provide the kind of notice that will enable ordinary people to understand what conduct it prohibits." In particular, "a fair warning should be given to the world in language that the common world will understand, of what the law intends to do if a certain line is passed. To make the warning fair, so far as possible the line should be clear." *United States* v. *Bass*, 404 U.S. 336, 348 (1971) (quoting *McBoyle* v. *United States*, 283 U.S. 25, 27 (1931) (Holmes, J.)); see *Sewell* v. *Georgia*, 435 U.S. 982, 986 (1978) (holding that a statute violates procedural due process when it fails to provide "a reasonable opportunity [for those regulated] to know what is prohibited, so that [they] may act accordingly" (quoting *Grayned* v. *City of Rockford*, 408 U.S. 104, 108 (1972)). The need for clear notice is even more pressing when a statute imposes criminal penalties on behavior that implicates constitutionally protected rights, see *Village of Hoffman Estates* v. *Flipside, Hoffman Estates, Inc.*,

455 U.S. 489, 498-99 (1982), as does a statute that trenches on a woman's fundamental liberty interest in deciding whether to continue a pregnancy. The line drawn by section 1531 simply does not distinguish in a reasonably clear manner between the abortions that it criminalizes and those that it does not.

Moreover, as this Court observed in *Bass*, there are situations in which "it is not unreasonable to imagine a citizen attempting to steer a careful course between violation of the statute and lawful conduct." 404 U.S. at 348 n.15 (quotation marks and internal brackets omitted) (quoting *United States* v. *Hood*, 343 U.S. 148, 151 (1952)). In particular, when federal law uses a jurisdictional element to criminalize conduct that states have chosen not to prohibit, "the notice problems of [the federal] law may be quite real." *Bass*, 404 U.S. at 348 n.15.

Section 1531 involves precisely such an area. Physicians who believe that the safest or most appropriate abortion technique in a particular context falls within section 1531(b)(1) may well find themselves trying to determine whether they should nonetheless perform the abortion using a less optimal technique because with respect to "the partial-birth abortion in question," H.R. Rep. No. 108-58, *supra*, at 26, they might be acting "in or affecting interstate . . . commerce." Because the statute fails to give adequate guidance on this question, the notice problem is both quite real and constitutionally unacceptable under the due process clause.

II. The Federalism-Related Values That Have Informed This Court's Recent Commerce Clause Cases Play an Especially Important Role Here.

The commerce power, while broad, is not a general police power. Thus, there remains "a distinction between what is truly national and what is truly local." *Lopez*, 514 U.S. at 567-68.

The statute before this Court implicates two distinctions this Court has repeatedly recognized. First, "regulation of health and safety is 'primarily, and historically, a matter of local concern,'" particularly when it comes to "the practice of medicine." *Gonzales* v. *Oregon*, 126 S. Ct. 904, 923 (2006) (quoting *Hillsborough County* v. *Automated Medical Laboratories, Inc.*, 471 U.S. 707, 719 (1985)); see also *Washington* v. *Glucksberg*, 521 U.S. 702 (1997). Second, "[u]nder our federal system, 'the States possess primary authority for defining and enforcing the criminal law.'" *Lopez*, 514 U.S. at 561 n.3. Given this history, it is not surprising that this Court's prior decisions regarding government restrictions on a woman's right to obtain and a physician's right to perform particular abortions have all involved state laws.

As in *Lopez*, where "considerable disagreement exist[ed] about how best to accomplish th[e] goal" of keeping guns away from schools, 514 U.S. at 581 (Kennedy, J., concurring), so with respect to abortion, considerable disagreement exists about how to balance a variety of competing concerns. To be sure, the Fourteenth Amendment sets boundaries beyond which states may not go in restricting women's access to abortions. See, *e.g.*, *Planned Parenthood* v. *Casey*, 505 U.S. 833 (1992); *Stenberg* v. *Carhart*, 530 U.S. 914 (2000). But even within the range of permissible abortion-related regulations, states take strikingly different positions. Some states, for example, mandate parental involvement (subject to a judicial bypass) in a minor's decision to terminate her pregnancy. See *Ayotte* v. *Planned Parenthood of Northern New England*, 126 S. Ct. 961, 966 n.1 (2006) (noting that 44 states have such laws). Some of those laws require parental consent, while some require only notice. And six states have declined to mandate any particular level of parental involvement. Similarly, while some states have abortion-specific informed consent or mandatory waiting period requirements, other states leave these issues up to the best judgments of women and their

physicians. See generally Guttmacher Institute, State Policies in Brief: Mandatory Counseling and Waiting Periods for Abortion (Aug. 1, 2006), at http://www.guttmacher.org/statecenter/spibs/spib_MWPA.pdf.

The Act, however, "forecloses the States from experimenting and exercising their own judgment in an area to which States lay claim by right of history and expertise." *Lopez*, 514 U.S. at 583 (Kennedy, J., concurring); see also *Gonzales* v. *Oregon*, 126 S. Ct. 904, 911 (2006) (noting that the effect of a federal rule prohibiting doctors nationwide from assisting in even state-approved decisions by terminally ill patients to end their lives would be to cut off "earnest and profound debate about the morality, legality, and practicality" of medical procedures that touch the most fundamental values in society (quoting *Washington* v. *Glucksberg*, 521 U.S. 702, 735 (1997)).

If section 1531 is upheld as a proper exercise of federal power, Congress will have been given the green light to regulate many other aspects of abortions that are currently the exclusive province of state laws, whether, as in this instance, to impose greater restrictions, or, in the future, to ease those that States have imposed that Congress finds too burdensome. Indeed, if this kind of abortion can be banned by Congress, it also would have the power to outlaw *any* "interstate" abortion, regardless of State law, subject only to whatever general constitutional limits remain. In short, sustaining the Act opens up the entire subject of abortion regulation to congressional second-guessing, thereby offending the basic balance between the federal and state governments on this issue.

And if regulation of abortion can be federalized, the same approach could permit Congress to re-work laws relating to marriage, divorce, adoption, probate, and the ownership of property, to name just a few other areas traditionally left to state and local regulation. Using the Act as an example, it would be relatively easy to find interstate effects from those

laws at least as substantial as those being conjured up for those abortions covered by the Act. And with those new laws, the federal system as it was created and followed throughout our history would be gone.[7]

The legislative history of section 1531 demonstrates no "serious inquiry into the necessity for federal regulation or the propriety of 'displac[ing] state regulation in areas of traditional state concern.'" *Raich*, 125 S. Ct. at 2238 (Thomas, J., dissenting) (quoting *Lopez*, 514 U.S. at 583 (Kennedy, J., concurring)). As Justice Thomas further observed in *Raich*, "Our federalist system, properly understood, allows California and a growing number of other States to decide for themselves how to safeguard the health and welfare of their citizens." *Id.* at 2239; cf. *Jones* v. *United States*, 529 U.S. 848, 859-60 (2000) (Stevens, J., joined by Thomas, J., concurring) (explaining that federal criminal statutes should be construed narrowly, "[e]ven when Congress has undoubted power to pre-empt local law" "unless Congress conveys its purpose clearly" to "effectively displace a policy choice made by the State").

Holding section 1531 invalid because it fails to provide reasonable notice as to what it does and does not forbid would not preclude Congress from trying to clarify its reach in language that can be understood by the physicians who are subject to its criminal penalties. And in the course of attempting such clarification, Congress could also seek to assemble a record and make appropriate findings regarding

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[7] For a general argument against the expansion of federal criminal jurisdiction and the excessive use of the commerce clause to create federal crimes, see Rachel Barkow, *Our Federal System of Sentencing*, 58 Stan. L. Rev. 119, 121-24 (2005). As Justice Scalia observed in *Rapanos* v. *United States*, 126 S. Ct. at 2224 n.8, States sometimes acquiesce in a federal takeover in these areas because they find it "attractive to shift to another entity controversial decisions disputed between politically powerful, rival interests."

the need for uniform nationwide regulation of those abortions covered by the Act. Nor would such a ruling prevent Congress from enacting a statute with a more well-defined interstate nexus. To the contrary, such a decision would serve as an appropriate reminder to Congress that there are limits under the commerce clause and that, when Congress approaches areas where the States have traditionally regulated, it should proceed with far more caution and far more precision than it has done here in assuring a proper exercise of its powers. Of course, none of these responses would solve the other constitutional problems identified by the courts of appeals, but this Court need not reach those questions in this case if it agrees with the arguments raised in this brief.

CONCLUSION

For the foregoing reasons as well as those in respondents' briefs, the judgment should be affirmed.

Respectfully submitted,

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In The Supreme Court of the United States

ALBERTO R. GONZALES, ATTORNEY GENERAL,
Petitioner,

v.

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., *ET AL.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF *AMICI CURIAE* OF CHRISTIAN LEGAL SOCIETY, NATIONAL ASSOCIATION OF EVANGELICALS, PRO-LIFE LEGAL DEFENSE FUND, ALLIANCE DEFENSE FUND AND CONCERNED WOMEN FOR AMERICA IN SUPPORT OF PETITIONER

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STATEMENTS OF INTEREST OF *AMICI CURIAE*[1]

The Statements of Interest of *Amici Curiae* Christian Legal Society, National Association of Evangelicals, Pro-Life Legal Defense Fund, Alliance Defense Fund and Concerned Women for America are set out in Appendix A hereto. All are nonprofit membership or advocacy organizations that have taken public positions against partial-birth abortion and have sought to end its practice by means of legislative action, education and legal advocacy.

SUMMARY OF ARGUMENT

For as long as the American public has known about partial-birth abortion, we have—by comfortable and consistent margins—agreed with former Senator Daniel Patrick Moynihan that this gruesome practice is "infanticide, and one would be too many." Meet the Press (NBC television broadcast, Mar. 2, 1997). Whether we oppose elective abortions as a matter of moral principle or regard a woman's legal access to abortion as a component of ordered liberty; whether we regret this Court's decisions in *Roe v. Wade*, 410 U.S. 113 (1973), and *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), as occasions of dramatic and damaging judicial overreaching or as vindications of privacy and autonomy; and whatever our views might be on a wide range of economic, social, and political questions, we have repeatedly and overwhelmingly concluded, in jurisdiction after jurisdiction, that partial-birth abortion is a barbarism that may and should be prohibited. The Court's *Amici*

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[1] *Amici curiae* file this brief by consent of the parties, and copies of the letters of consent are on file with the Clerk of the Court. Counsel for *Amici* authored this brief in its entirety. No person or entity, other than the *amici curiae*, their supporters, or their counsel, has made a monetary contribution to the preparation or submission of this brief.

believe this conclusion is entirely consistent with our shared, abiding commitment to individual freedom under and through the rule of law, and it is one that our Constitution permits us to embrace. In our "democratic society," the debate over partial-birth abortion continues, and this Court should not cut it short. *Cf. Washington v. Glucksberg*, 521 U.S. 702, 735 (1997) ("Our holding permits this debate to continue, as it should in a democratic society.").

This case presents the question whether the United States Court of Appeals for the Ninth Circuit erred in concluding that the Partial-Birth Abortion Ban Act of 2003 ("the Act"), Pub. L. No. 108-105, 117 Stat. 1201, is unconstitutional. *Amici* believe it did. As Petitioner the United States makes quite clear, the Act defines the prohibited conduct with sufficient precision, *Gonzales v. Carhart*, No 05-380, Petition for a Writ of Certiorari, at 2-3, and is supported by Congress's extensive factual findings and conclusion that "partial-birth abortion is never medically indicated to preserve the health of the mother," *id.* at 3 (quoting Sec. 2(14)(O), 117 Stat. at 1206). The decision below is neither required nor justified by this Court's previous partial-birth abortion decision, *Stenberg v. Carhart*, 530 U.S. 914 (2000), or by *Casey* and *Roe*.

In this brief, *Amici* respectfully submit that the task appropriately before the Court is not so much to parse the opinions in *Stenberg* or to identify the distinctions between the Act under review here and the one previously invalidated. Instead, the central issue that the Court may and should resolve here is whether *Stenberg* should be overruled. Although, as the United States has demonstrated, the Act *can* be distinguished meaningfully from the Nebraska law struck down in *Stenberg*, we believe that this Court's time and constitutional powers would be better spent, and the rule of law better served, if *Stenberg* were abandoned as wrongly decided and inconsistent with *Casey's* promise that to uphold

a basic right to abortion was not to disable entirely We the People from reasonably regulating the exercise of that right, let alone from outlawing so brutal and brutalizing a practice as partial-birth abortion.

Accordingly, *Amici* in this brief address two principal matters: *First,* the appropriate weight of *stare decisis* to be applied in this case; and *second,* the majority's misguided embrace in *Stenberg* of an extreme and unreasonable understanding of the "health"-related reasons thought to override limits on late-term abortion procedures.

With respect to the first point, we submit that *stare decisis* need not, and should not, preclude reconsideration and rejection of *Stenberg*. That case is recent; it was decided by a closely divided Court, over strenuous – and persuasive – dissents; it has not been reaffirmed repeatedly, nor has it served as the foundation for a body of law or line of cases; it is an outlier even in its relatively discrete area; it cannot reasonably be regarded as having created reliance interests; and, most important, it was wrongly decided.

Given all these circumstances and considerations, the Court's *stare decisis* case-law poses no barrier to revisiting *Stenberg*. As this Court has emphasized repeatedly, *stare decisis* is not an "inexorable command;" it is instead a "'principle of policy and not a mechanical formula of adherence to the latest decision.'" *Payne v. Tennessee,* 501 U.S. 808, 828 (1991) (quoting *Helvering v. Hallock,* 309 U.S. 106, 119 (1940)). This Court has on regular occasions, upon careful reflection, overruled what it regards as wrongly decided cases and unwarranted divergences from earlier, settled law. *See, e.g., Lawrence v. Texas,* 539 U.S. 558 (2003); *Atkins v. Virginia,* 536 U.S. 304 (2002); *Agostini v. Felton,* 521 U.S. 203 (1997). Indeed, even in *Planned Parenthood v. Casey*, this Court – while reaffirming what it characterized as the "central holding" of *Roe v. Wade*, *Casey,*

505 U.S. at 853, 855, 858 – overruled two previous decisions that it came to see as excessive, unjustified extensions of *Roe*. 505 U.S. at 882 (overruling in part *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747 (1986), and *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983)). This case presents the Court with a welcome opportunity to reconsider *Stenberg*'s similarly unwarranted and extreme extension of that case.[2]

Turning to our second point: *Stenberg*, which was the basis for the decision below, was wrongly decided. The Ninth Circuit Court of Appeals invalidated the will of the People as expressed in the Act because of *Stenberg*. *See Planned Parenthood v. Gonzales*, 435 F.3d 1163, 1175 (2006) ("[W]e are compelled [by *Stenberg*] to hold that a health exception is constitutionally required."). However, nothing in the text, history, or structure of our Constitution, nothing in our traditions, none of this Court's precedents, and none of our deeply rooted values support the conclusion that the Constitution disables the American people from affirming our commitments to democracy, individual freedom, and the lives of vulnerable unborn – or, in this case, being-born – children by rejecting partial-birth abortion. This Court has affirmed repeatedly that governments have compelling interests in protecting the lives of unborn children, particularly after they are able to live outside their mother's body. *See, e.g., Casey*, 505 U.S. at 871; *Stenberg*, 530 U.S. at 961 (Kennedy, J., dissenting); *id.* at 1006-07 (Thomas, J., dissenting). Further, if any government interest is *especially* compelling, it is the interest in preventing a

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[2] *Amici* believe that *Roe* was wrongly decided and is best regarded – in Justice White's words – as an exercise of "raw judicial power." *Roe*, 410 U.S. at 222 (White, J., dissenting). There is no need, however, to revisit *Roe*, or *Casey*, in order to reject *Stenberg* and affirm the constitutional validity of the Act.

procedure that is, in effect, infanticide – the intentional killing a living human being in the process of being born. *Id.* at 960 (Kennedy, J., dissenting) ("[I]t should go without saying that Nebraska's ban on partial birth abortion furthers purposes States are entitled to pursue."); *id.* at 953 (Scalia, J., dissenting). Nothing in *Roe* or *Casey* supports, let alone compels, the extreme conclusion that the right to abortion is so unyielding and sweeping as to trump the public's repeated efforts to reject partial-birth abortion. In *Stenberg*, a bare majority of this Court held that the Nebraska partial-birth abortion law under review was invalid because, although it permitted the procedure in cases where it is necessary to save a mother's *life*, it did not include a similar exception for cases where a partial-birth abortion is necessary to preserve a mother's *health*. *Stenberg*, 530 U.S. at 930-38. As the court below stated, "*Stenberg* holds that an abortion regulation that fails to contain a health exception is unconstitutional except when there is a medical consensus that no circumstance exists in which the procedure would be necessary to preserve a woman's health." *Planned Parenthood*, 435 F.3d at 1172. *See also Carhart v. Gonzales*, 413 F.3d 791, 792 (8th Cir. 2005), *cert. granted*, 126 S.Ct. 1314 (2006) ("[T]he Court [in *Stenberg*] determined the law was unconstitutional because it did not contain an exception to preserve the health of the mother."). And, the court below concluded, "*Stenberg* reaffirms . . . that the Constitution requires that *any* abortion regulation must contain such an exception." *Planned Parenthood*, 435 F.3d at 1172 (emphasis added); *see also Carhart*, 413 F.3d at 796; *Richmond Medical Center for Women v. Hicks*, 409 F.3d 619, 625 (4th Cir. 2005).

The majority in *Stenberg* asserted that where "substantial medical authority supports the proposition that banning a particular abortion procedure could endanger women's health," the statute must include a health exception. *Stenberg*, 530 U.S. at 938. Imposing an impossible evidentiary burden upon the States, the majority concluded

that Nebraska "fail[ed] to demonstrate that banning [partial-birth abortion] without a health exception may not create significant health risks for women." *Id.* at 932. In fact, however, as Congress found, "partial-birth abortion is never medically indicated to preserve the health of the mother," Sec. 2(14)(O), 117 Stat. at 1206, and "[t]here is no credible medical evidence that partial-birth abortions are safe or are safer than other abortion procedures." Sec. 2(14)(B), 117 Stat. at 1204. In the face of Congress's careful investigation of the matter, and its repeated and well considered conclusion that partial-birth abortions – *i.e.*, these *particular* methods of abortion – are never medically necessary to protect a mother's health, it was in *Stenberg*, and would be in this case, a dramatic and unjustifiable act of judicial hubris and overreaching to invalidate the public's conclusion that partial-birth abortion may and should be prohibited.

In addition to questions relating to the deference due to Congress's judgments about medical necessity, or to the merits of the view that *every* regulation of abortion – *i.e.*, not only prohibitions, but also what might be thought of as time, place, or manner regulations – requires a "health" exception, there is in this case a more fundamental question about the constitutionalization of a practically limitless definition of "health." The understanding at work in *Stenberg*, and thus in the opinion of the court below, is so sweeping as to include *any* reason a woman might have for wishing to end the life of her unborn, or partially-born, viable child. On that understanding, derived from *Doe v. Bolton*, 410 U.S. 179 (1973), it is apparently not even enough for legislatures to carve out of abortion regulations exceptions relating to serious dangers to a women's physical health. Instead, they must effectively gut the regulations, yielding to a "health" exception that accounts for "all factors – physical, emotional, psychological, familial, and the woman's age – relevant to the well-being of the patient." *Id.* at 192.

This Court should take the opportunity presented in this case to correct *Stenberg*'s mistaken view that, in *any* case where there is *any* disagreement about the need for a health-related exception from *any* abortion-related regulation, the absence of such an exception is fatal to the regulation. It should also re-examine and refine the definition of "health" that was constitutionalized in *Bolton* and other cases, and should make clear that, given the compelling public interest in protecting viable unborn human life, any health-exception requirement need not and should not function as a loophole permitting elective abortion up to and including the moment before birth.

This Court's decision in *Casey* reaffirmed the "central holding" of *Roe,* but it did not purport to so cripple the democratic process, or so entirely subordinate the considered judgments of the American people, as to make it impossible to find common ground and compromise in our national debates over abortion. The majority's decision in *Stenberg* can only be seen as a repudiation of the balancing, deliberation, and compromise by the respective assemblies of the States and the United States that *Casey* invited. As Justice Kennedy wrote in *Stenberg:*

> The political processes of the State are not to be foreclosed from enacting laws to promote the life of the unborn and to ensure respect for all human life and its potential. . . . The State's constitutional authority is a vital means for citizens to address these grave and serious issues, as they must if we are to progress in knowledge and understanding and in the attainment of some degree of consensus.
>
> The Court's decision today, in my submission, repudiates this understanding[.]

Stenberg, 530 U.S. at 957 (Kennedy, J., dissenting). This repudiation of the proper political processes of the States and

the United States can, and should, be undone.

ARGUMENT

I. PRINCIPLES OF *STARE DECISIS* DO NOT REQUIRE CONTINUED ADHERENCE TO *STENBERG V. CARHART*.

In *Stenberg v. Carhart*, a narrow majority of this Court found in its abortion precedents a constitutional right to partial-birth abortion, one that effectively immunizes this controversial practice from democratically enacted and broadly supported regulations. A partial-birth abortion – also known as "dilation and extraction" (D & X) or "intact dilation and evacuation" (intact D & E) – is a late gestation abortion procedure whereby a physician partially delivers the intact, living unborn child up to the head (in the case of a breech presentation) or up to the waist (in the case of a head-first presentation) and then, just before the moment of birth, kills the nearly born child by puncturing his or her skull and vacuuming out the brain. As the dissent in *Stenberg* noted, one witness to the procedure described it this way:

> The baby's little fingers were clasping and unclasping, and his little feet were kicking. Then the doctor stuck the scissors in the back of his head, and the baby's arms jerked out, like a startle reaction, like a flinch, like a baby does when he thinks he is going to fall. The doctor opened up the scissors, stuck a high-powered suction tube into the opening, and sucked the baby's brains out. Now the baby went completely limp.

Stenberg, 530 U.S. at 1007 (Thomas, J., dissenting); *see also id.* at 959-60 (Kennedy, J., dissenting) ("With only the head of the fetus remaining in utero, the abortionist tears open the skull. According to Dr. Martin Haskell, a leading proponent of the procedure, the appropriate instrument to be used at this

stage of the abortion is a pair of scissors. . . . Brain death does not occur until after the skull invasion, and, according to Dr. Carhart, the heart of the fetus may continue to beat for minutes after the contents of the skull are vacuumed out."). As Justice Scalia noted in that case, "[this] method of killing a human child – one cannot even accurately say an entirely unborn human child – proscribed by [the Nebraska law] is so horrible that the most clinical description of it evokes a shudder of revulsion." *Id.* at 953 (Scalia, J., dissenting). Nevertheless, the majority in *Stenberg* struck down the Nebraska law – and, in so doing, nullified dozens of similar laws enacted by the States – as impermissibly vague, because it assertedly applied more broadly than just to partial-birth abortions, *id.* at 939-40, and because it failed to include a "health" exception, *id.* at 938.

As we discuss in more detail below, *Amici* are confident that *Stenberg* is neither required nor justified by the Constitution, and was an unwarranted and improper expansion of, and departure from this Court's decision in *Planned Parenthood v. Casey*. In brief, *Stenberg* was a mistake that this Court may and should correct.[3] That is, if a majority of the Justices of this Court, after careful re-consideration of the arguments presented and endorsed in *Stenberg*, is persuaded that the case was wrongly decided, then *stare decisis* considerations do not preclude this Court from overruling it. Such a course would both respect and vindicate the rule of law.

A. *Stare Decisis* is a Doctrine of Judicial Policy, not

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[3] Again, we do not reject the possibility that there are differences between the Act and the law invalidated in *Stenberg*, and do not deny that the Act may be upheld by distinguishing and limiting, rather than overruling, *Stenberg*. Nevertheless, it is our view that *Stenberg* should be overruled and that *stare decisis* considerations pose no obstacle to overruling it.

a Constitutional Requirement of Strict and Unyielding Adherence to Mistaken Precedents.

This Court has consistently made clear that the doctrine of *stare decisis* is not an "inexorable command" of unquestioning adherence to the most recently decided case. It is not, as Justice Frankfurter once put it, the "imprisonment of reason." *United States v. Int'l Boxing Club of N.Y., Inc.*, 348 U.S. 236, 249 (1955) (Frankfurter, J., dissenting). Rather, it is a principle of sound judicial *policy*. *Planned Parenthood v. Casey*, 505 U.S. 833, 854-55 (1992) (collecting and quoting cases); *Agostini v. Felton*, 521 U.S. 203, 235 (1997) (*stare decisis* is "a policy judgment" rather than an inflexible requirement); *Seminole Tribe of Florida v. Florida*, 517 U.S. 44, 63 (1996) (quoting *Helvering v. Hallock*, 309 U.S. 106, 119 (1940) and *Payne v. Tennessee*, 501 U.S. 808, 828 (1991)) ("[W]e always have treated *stare decisis* as a 'principle of policy' . . . and not as an 'inexorable command'"); *Payne*, 501 U.S. at 827-30 & n.1 (collecting cases); *Patterson v. McLean Credit Union*, 491 U.S. 164, 171-75 (1989); *id.* at 172 (*stare decisis* is a "basic self-governing principle within the Judicial Branch" but the Court has "overruled prior decisions where the necessity and propriety of doing so has been established"); *Helvering*, 309 U.S. at 119 ("*stare decisis* is a principle of policy and not a mechanical formula of adherence to the latest decision"). As Justice O'Connor noted in *Adarand Constructors, Inc. v. Pena*:

> Remaining true to an "intrinsically sounder" doctrine established in prior cases better serves the values of *stare decisis* than would following a more recently decided case inconsistent with the decisions that came before it; the latter course would simply compound the recent error and would likely make the unjustified break from previously established doctrine complete.

515 U.S. 200, 231 (1995) (Opinion of O'Connor, J., joined by Kennedy, J.)

In accord with the judicial policy of *stare decisis,* it is well to adhere to a course of settled decisions, and not to depart from or upset it, absent a special justification for overruling prior precedents that otherwise might be conceded to have been erroneous. *Casey*, 505 U.S. at 854 (joint opinion) ("[W]hen this Court reexamines a prior holding, its judgment is customarily informed by a series of prudential and pragmatic considerations designed to test the consistency of overruling a prior decision with the ideal of the rule of law, and to gauge the respective costs of reaffirming and overruling a prior case."); *Payne*, 501 U.S. at 828 (noting that "the Court [had] during the past 20 Terms overruled in whole or in part 33 of its previous constitutional decisions"); *id.* at 842-43 (Souter J., joined by Kennedy, J., concurring) ("[W]hen this Court has confronted a wrongly decided, unworkable precedent calling for some further action by the Court, we have chosen not to compound the original error, but to overrule the precedent."). Such "special justification" exists when precedent is "inconsistent with the decisions that came before it" because following such precedent "would simply compound the recent error." *Adarand,* 515 U.S. at 231 (Opinion of O'Connor J., joined by Kennedy J.). It exists also when the precedent "lack[s] constitutional roots," *id.* at 232 (quoting *United States v. Dixon,* 509 U.S. 688, 704 (1993)), or was an "abrupt and largely unexplained departure from precedent," *id.* at 233 (quoting *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36, 47 (1977)). *See also, e.g., Seminole Tribe*, 517 U.S. at 63 (quoting *Payne,* 501 U.S. at 827) ("'[W]hen governing decisions are unworkable or are badly reasoned, this Court has never felt constrained to follow precedent.'").

The policy of *stare decisis* does and should exercise a weaker pull on the Court's decisionmaking in constitutional

cases. After all, such decisions may only be reversed by the Court itself, or through the very difficult method of constitutional amendment. *Agostini*, 521 U.S. at 235 (*stare decisis* is "at its weakest when we interpret the Constitution because our interpretation can be altered only by constitutional amendment or by overruling our prior decisions"); *Seminole Tribe*, 517 U.S. at 63 (quoting *Payne*, 501 U.S. at 828) ("Our willingness to reconsider our earlier decisions has been 'particularly true in constitutional cases, because in such cases correction through legislative action is practically impossible.'"); *Glidden Co. v. Zdanok*, 370 U.S. 530, 543 (1962) (noting the Court's "considered practice not to apply *stare decisis* as rigidly in constitutional as in nonconstitutional cases"); *Smith v. Allwright*, 321 U.S. 649, 665 (1944) ("In constitutional questions... this Court throughout its history has freely exercised its power to reexamine the basis of its constitutional decisions."); *St. Joseph Stock Yards Co. v. United States*, 298 U.S. 38, 94 (1936) (Stone & Cardozo, JJ., concurring in the result) ("The doctrine of *stare decisis* . . . has only a limited application in the field of constitutional law.").

Indeed, in *Casey* itself – where this Court, on *stare decisis* grounds, re-affirmed what it described as the "central holding" of *Roe,* 505 U.S. at 854-69 – this Court clearly modified the relevant constitutional rules and *Roe*'s rigid "trimester" framework, *id.* at 872-73. The Court did not hesitate in *Casey* to overrule outright two prior decisions that had gone too far in expanding the right to abortion and tying the hands of legislators, *see id.* at 882 (overruling in part *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747 (1986), and *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416 (1983)).

In sum, any blanket claim that *stare decisis* principles or rule-of-law commitments *require* strict adherence to

precedent, no matter how misguided that precedent may be, is untenable. Indeed, and ironically, such a claim would be *unprecedented*, given that this Court's cases teach consistently and clearly that the doctrine of *stare decisis* is a flexible, practical one that admits of substantial judicial discretion as to how the policies underlying the doctrine should be applied in any given set of circumstances.

B. The Principles of *Stare Decisis* Permitting Reconsideration of Prior Decisions Support the Reconsideration and Overruling of *Stenberg*.

Given the principles and practices outlined above, this Court's decision in *Stenberg* properly may be overruled. In fact, a number of considerations weigh strongly against affirming *Stenberg* simply on *stare decisis* grounds. First, the decision is of very recent origin. *See Adarand*, 515 U.S. at 231 (Opinion of O'Connor J., joined by Kennedy, J.) (following "intrinsically sounder doctrine" serves *stare decisis* more "than would following a more recently decided case inconsistent with the decisions that came before it"); *Payne*, 501 U.S. at 828-30 (overruling recent decisions in *Booth v. Maryland*, 482 U.S. 496 (1987), and *South Carolina v. Gathers*, 490 U.S. 805 (1989)). Next, the decision in *Stenberg* was issued by a deeply divided Court, and produced several powerful dissents. *See Payne*, 501 U.S. at 828-30 (*stare decisis* a lesser consideration when a prior decision was made on a close vote over "spirited dissents").

Another fact that weighs heavily against according *Stenberg* constraining precedential weight is that the decision in that case was itself a striking departure from earlier precedent. *Stenberg*, 530 U.S. at 957 (Kennedy, J., dissenting) (noting that *Stenberg* "repudiate[d]" the *Casey* Court's understanding that "[t]he political processes of the State are not to be foreclosed from enacting laws to promote the life of the unborn and to ensure respect for all human life

and its potential"); *see also, e.g., Adarand*, 515 U.S. at 231, 233 (Opinion of O'Connor, J., joined by Kennedy, J.) (noting diminished *stare decisis* weight where a decision is "inconsistent with the decisions that came before it" or "an abrupt and largely unexplained departure from precedent"). That is, *Stenberg* is not well grounded in the Constitution's text, history, or structure; and its unwarranted extension of earlier cases (and repudiation of *Casey*) means that it can be said to "lack constitutional roots." *Id.* at 232.

It is also important to appreciate that *Stenberg* has not been reaffirmed in subsequent cases of this Court, has not enjoyed or inspired the sustained acquiescence and endorsement of the public or of other branches of government, and has not become embedded in our practices or traditions. *Cf. Dickerson v. United States,* 530 U.S. 428, 443 (2000) (*stare decisis* strongly supported *Miranda v. Arizona*, 384 U.S. 436 (1966), because its rule had become "embedded in routine police practice to the point where the warnings have become part of our national culture"). Quite the contrary: The legislatures of most states, like the Congress of the United States, have banned partial-birth abortion. *Cf. Atkins v. Virginia,* 536 U.S. 304, 314-16 (2002) (many of the states had, in the years after *Penry v. Lynaugh,* 492 U.S. 302 (1989), taken steps to exempt developmentally disabled persons from death-eligibility). Nor is *Stenberg* the rare case in which the Court could plausibly be said to have invested its own prestige in the merits and survival of the precedent. *Cf. Casey*, 505 U.S. at 866-69.

Finally, *Stenberg* simply cannot be thought to have created reasonable reliance interests in the availability-on-demand of this particular type of elective abortion procedure. Congress, like the legislatures of most states and the overwhelming majority of the American people, has considered and rejected the idea that the availability of this *particular* – and particularly troubling – abortion procedure

is essential to a woman's right to an abortion. *See Stenberg*, 530 U.S. at 957 (Kennedy, J., dissenting) (noting that the Nebraska ban on partial-birth abortion "denie[d] no woman the right to choose an abortion and place[d] no undue burden upon the right"). Certainly, no men or women have "ordered their thinking and living" around an imagined constitutional right to obtain an abortion via this particular method. *Cf. Casey*, 505 U.S. at 856.

In case after case, each one of these factors has been recognized by this Court as justifying overruling or departing from a prior case or line of cases that is recognized as unsound. Thus, if this Court concludes – as we believe it should – that *Stenberg* was wrongly decided, neither *stare decisis* nor our commitment to stability and the rule of law requires continued adherence to that decision. This Court's decisions involving the content and application of the *stare decisis* principle weigh heavily in favor of discarding *Stenberg*.

C. President Lincoln's Statements Concerning the Weight of Judicial Precedents Provide a Useful Benchmark for Deciding When it is Appropriate to Overrule Prior Decisions.

This Court's cases involving the *stare decisis* doctrine bear a strong and instructive resemblance to principles set forth by Abraham Lincoln, when he was a candidate for the United States Senate. Lincoln confronted the argument that the Court's decision in the *Dred Scott* case (*Scott v. Sandford*, 60 U.S. (19 How.) 393 (1857)) was settled, binding law, and that those who would seek to have it overruled were disrespectful of judicial authority and of the Constitution. Lincoln's response merits quotation at length:

> Judicial decisions have two uses – first, to absolutely determine the case decided, and secondly,

to indicate to the public how other similar cases will be decided when they arise. For the latter use, they are called "precedents" and "authorities."

We believe... in obedience to, and respect for the judicial department of government. We think its decisions on Constitutional questions, when fully settled, should control, not only the particular cases decided, but the general policy of the country, subject to be disturbed only by amendments of the Constitution as provided in that instrument itself. More than this would be revolution. But we think the Dred Scott decision is erroneous. We know the court that made it, has often overruled its own decisions, and we shall do what we can to have it to over-rule this.

If this important decision had been made by the unanimous concurrence of the judges, and without any apparent partisan bias, and in accordance with legal public expectation, and with the steady practice of the departments throughout our history, and had been in no part, based on assumed historical facts which are not really true; or, if wanting in some of these, it had been before the court more than once, and had there been affirmed and re-affirmed through a course of years, it then might be, perhaps would be, factious, nay, even revolutionary, to not acquiesce in it as a precedent.

But when, as it is true, we find it wanting in all these claims to the public confidence, it is not resistance, it is not factious, it is not even disrespectful, to treat it as not having yet quite established a settled doctrine for the country....

Abraham Lincoln, Speech at Springfield, Illinois (June 26, 1857), *reprinted in* ABRAHAM LINCOLN: SPEECHES AND WRITINGS, 1832-58: SPEECHES, LETTERS, AND MISCELLANEOUS WRITINGS, THE LINCOLN-DOUGLAS

DEBATES 390, 390-92 (Library of America ed., 1989). Lincoln's statement of principles is characteristically compelling. And, it is consistent with this Court's own statements concerning the force of precedent. The Court's *Amici* submit that the principles he defended supply important guidance as to when it is proper for this Court to overrule its prior decisions.

First, Lincoln notes that the Court's decisions *absolutely* determine the individual cases decided, even if one might think the Court's judgments erroneous. Later, in his First Inaugural, Lincoln elaborated that such decisions "must be binding in any case, upon the parties to a suit." Abraham Lincoln, First Inaugural Address (March 4, 1861), *reprinted in* ABRAHAM LINCOLN: SPEECHES AND WRITINGS, 1859-65: SPEECHES, LETTERS, MISCELLANEOUS WRITINGS, PRESIDENTIAL MESSAGES AND PROCLAMATIONS 215, 221 (Library of America ed., 1989). While it is "obviously possible that such decision may be erroneous in any given case, still the evil effect following it, being limited to that particular case, with the chance that it may be over-ruled, and never become a precedent for other cases, can better be borne than could the evils of a different practice." *Id.* at 221. This Court, of course, has long embraced this principle. *Cf. Cooper v. Aaron*, 358 U.S. 1 (1958). This does not mean, however – it *could not* mean – that the Court's decisions, as *precedents*, are absolutely binding and immune from reconsideration. Rather, such constitutional decisions control the general policy of the nation only when they have become *"fully settled" by virtue of a sustained course of judicial decision and public acquiescence by other actors in our constitutional system.* Abraham Lincoln, Speech at Springfield, Illinois (June 26, 1857), *supra,* at 393.

In Lincoln's day (as in ours) it was widely recognized that the Court "has often overruled its own decisions," *id.*, and that it was appropriate to seek to have the Court overrule

a case like *Dred Scott*. Again, this Court's doctrine is similar: While every judgment of the Court is authoritative and binding, *no* precedent is beyond the Court's reconsideration, if there are persuasive reasons to believe the decision wrong and continued adherence to it would be harmful. Only if a decision has been *fully settled by long practice and acceptance* does it become so sufficiently part of the fabric of the law as to be exempt from this usual rule permitting overruling. Abraham Lincoln, Speech at Springfield, Illinois (June 26, 1857), *supra*, at 393 (noting significance of whether a decision accords with "legal public expectation, and with the steady practice of the departments throughout our history"). Thus it is that even a case like *Plessy v. Ferguson*, 163 U.S. 537 (1896) – though used as a basis for other decisions over a period of more than half a century, and surely relied on to some extent by many – remained deeply contested and thus unsettled. The Court's decision to reconsider and overrule it in *Brown v. Board of Education*, 347 U.S. 483 (1954), was fully consistent with Lincoln's principle. *See Casey*, 505 U.S. at 862-64 (noting propriety of *Brown*'s overruling of *Plessy*).

Lincoln appreciated, as have the Justices of this Court, that some precedents carry less authority than others. Judicial decisions, he observed, "are of greater or less authority as precedents, according to circumstances. That this should be so, accords both with common sense, and the customary understanding of the legal profession." Abraham Lincoln, Speech at Springfield, Illinois (June 26, 1857), *supra*, at 393; *cf. Casey*, 505 U.S. at 854 (noting that "when this Court reexamines a prior holding, its judgment is customarily informed by a series of prudential and pragmatic considerations" designed to "gauge" the appropriate weight of prior decisions and the costs and benefits of overruling in a particular instance). The reasons invoked by Lincoln as proper grounds for overturning precedent are remarkably similar to the ones identified by this Court's recent doctrine:

It is relevant whether the decision is one of extremely long standing, such that its rule has become entrenched in established practice and accords with "legal public expectation, and with the steady practice of the departments throughout our history." Lincoln, Speech at Springfield, Illinois (June 26, 1857), *supra,* at 393. Similarly, this Court has treated precedent as being strongest where public institutions, or private reliance interests, have grown up around a decision. *See, e.g., Payne*, 501 U.S. at 828 ("Considerations in favor of *stare decisis* are at their acme in cases involving property and contract rights, where reliance interests are involved"); *Pennsylvania v. Union Gas Co.*, 491 U.S. 1, 34 (1989) (Scalia, J., concurring in part and dissenting in part) (noting significant public institutional reliance on Court's earlier sovereign immunity decisions for nearly a century "and the difficulty of changing, or even clearly identifying, the intervening law that has been based on that answer"). In this respect, *stare decisis* can be seen as "the application to judicial precedents of a more general principle that the settled practices and expectations of a democratic society should generally not be disturbed by the courts." *Payne*, 501 U.S. at 834-35 (Scalia, J., concurring). As Lincoln noted, the converse is equally true: Where the settled practices and expectations of a democratic society do *not* agree with a judicial precedent, the precedent cannot be regarded as having become a fully settled part of the fabric of the law.

The degree to which a decision has commanded unanimous or near-unanimous support within the Court is also relevant, especially with respect to precedents of recent vintage. As Lincoln put it, it would certainly have mattered had *Dred Scott*, or any other decision, "been made by the unanimous concurrence of the judges, and without any apparent partisan bias." Abraham Lincoln, Speech at Springfield, Illinois (June 26, 1857), *supra,* at 393; *cf. Payne,* 501 U.S. at 828-29 (noting that "*Booth* and *Gathers*

were decided by the narrowest of margins, over spirited dissents").[4]

Finally, Lincoln remarked that, even if a decision were "wanting" in some of the usual attributes of enduring precedents, it might nonetheless be "factious . . . to not acquiesce in it as a precedent" if the issue "had been before the court more than once, and had there been affirmed and re-affirmed through a course of years[.]" Abraham Lincoln, Speech at Springfield, Illinois (June 26, 1857), *supra,* at 393. Surely, a case that has been re-affirmed often and regularly will enjoy great precedential weight and deference. At the same time, a relatively recent case that has not been reaffirmed or settled into a body of law or line of cases would not necessarily deserve the same treatment. To be sure, there have been judicial decisions and doctrines that, even though reaffirmed repeatedly, were so wrong as to be beyond the reach of this kind of respect. For example, *Plessy* stood for fifty-eight years, and was a premise for many subsequent decisions of this Court before *Brown v. Board of Education* interred its unsound holding. Thus, while it is true that long adherence to a judicial doctrine may be a factor in favor of its retention (at least in doubtful or close cases), that consideration should not override all others. At the very least, the time period and degree of

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[4] To be clear: We do not mean to suggest that *Dred Scott* should have been accepted as a precedent, or validly could be thought immune to reconsideration, had it been unanimous. (The decision was 7-2 in support of the Court's disposition and opinion.) Rather, we note the descriptive correctness of Lincoln's evaluation that the degree of judicial consensus certainly matters to the authority any particular precedent may be thought to carry for future decisions, as does the persuasiveness (or lack thereof) of the Court's reasoning. These factors certainly detracted from the precedential weight, and deference, to be accorded the Court's *Dred Scott* decision.

reaffirmation necessary to consider a course of judicial decisions as having "settled" a debatable proposition of constitutional law should be very extensive indeed. Lincoln's proposition is perhaps most persuasive when formulated in the negative: The *absence* of a long period of sustained judicial embrace of a questionable doctrine is an important factor *against* according such decisions strong *stare decisis* weight.

The application of Lincolnian principles to *Stenberg* is, we submit, quite obvious, and accords with the earlier discussion of this Court's *stare decisis* cases. If this Court believes that *Stenberg* was wrongly decided – *i.e.*, an incorrect interpretation of the Constitution, and an unsound extension of prior case law judicial doctrine – it should be overruled. The decision was not "made by the unanimous concurrence of the judges," but a hotly contested 5-4 decision, supported by a narrow concurring opinion. *See* 530 U.S. at 947-51 (O'Connor, J., concurring). The decision is not "in accordance with legal public expectation" and "the steady practice of the departments throughout our history." Abraham Lincoln, Speech at Springfield, Illinois (June 26, 1857), *supra,* at 393. Rather, it is a still-recent and tendentious departure from prior decisions of the Court, *see Stenberg,* 530 U.S. at 957 (Kennedy, J., dissenting) ("The Court's decision . . . repudiates [*Casey*'s] understanding[.]"). It certainly has not received the approbation of the other departments of government. And, this six-year-old decision has not been "before the court more than once" or "affirmed and re-affirmed through a course of years." Abraham Lincoln, Speech at Springfield, Illinois (June 26, 1857), *supra,* at 393. What Lincoln said of *Dred Scott* is true of *Stenberg:* "But when, as it is true we find it wanting in all these claims to the public confidence, it is not resistance, it is not factious, it is not even disrespectful, to treat it as not having yet quite established a settled doctrine for the country." *Id.*

II. THE CONSTITUTION DOES NOT REQUIRE ABORTION REGULATIONS TO INCLUDE SWEEPING AND SELF-DEFEATING "HEALTH" EXCEPTIONS.

The court below invalidated the Act because, in its view, *Stenberg* "requires that any abortion regulation must contain [a health] exception." *Planned Parenthood*, 435 F.3d at 1172. *See also Carhart*, 413 F.3d at 796 (*Stenberg* "establishes a *per se* constitutional rule" that "a health exception applies to all abortion statutes."). Noting that the Act does not contain such an exception, the Court of Appeals said that it was compelled to hold that "Congress's failure to include a health exception in the statute renders the Act unconstitutional." *Planned Parenthood*, 435 U.S. at 1176. *See also id.* at 1172 ("*Stenberg* holds that an abortion regulation that fails to contain a health exception is unconstitutional except when there is a medical consensus that no circumstance exists in which the procedure would be necessary to preserve a woman's health."); *Carhart*, 413 F.3d at 803 ("Because the Act does not contain a health exception, it is unconstitutional.").

In *Stenberg* itself, the narrow majority (citing *Casey*, 505 U.S. at 880) reasoned that, because "the law requires a health exception in order to validate even a postviability abortion regulation, it at a minimum requires the same in respect to previability regulation." *Stenberg*, 530 U.S. at 930; *see also id.* at 931 (*quoting Casey*, 505 U.S. at 879) ("[T]he governing standard requires an exception 'where it is necessary, in appropriate medical judgment for the preservation of the life or health of the mother[.]'"); *id.* at 938 (quoting *Casey*, 505 U.S. at 879) ("[W]here substantial medical authority supports the proposition that banning a particular abortion procedure could endanger women's health, *Casey* requires the statute to include a health exception when the procedure is 'necessary, in appropriate

medical judgment, for the preservation of the life or health of the mother.'").

In our view, it simply is not the case that the Constitution, properly understood, requires every regulation of abortion *procedures* to include an amorphous, *Bolton*-style "health" exception. We agree with Petitioner, many other *Amici*, and Congress's investigation and findings regarding the lack of any medical necessity or health-protecting justifications for partial-birth abortion. That said, *Amici* urge this Court to revisit and clarify its decisions relating to health exceptions and abortion laws, and to clarify that the Constitution does not require legislators, and the People, to enact self-defeating and meaningless abortion regulations with health exceptions that, in effect, swallow the regulations themselves. *See, e.g., Stenberg*, 530 U.S. at 965 (Kennedy, J., dissenting) ("Requiring Nebraska to defer to Dr. Carhart's judgment is no different from forbidding Nebraska from enacting a ban at all[.]").

To be clear: The decision of the court below, like that of this Court in *Stenberg*, renders meaningless the assurances provided in *Casey* – *i.e.*, that notwithstanding the abortion right created in *Roe*, "the States retain a critical and legitimate role in legislating on the subject of abortion," *Stenberg*, 530 U.S. at 956-57 (Kennedy, J., dissenting) – in at least two ways. First, what might be called the "triggering condition" for the health-exception requirement is "appropriate medical judgment," which in effect "awards each physician a veto power over the State's judgment that the procedures should not be performed." *Id.* at 964 (Kennedy, J., dissenting). Justice Kennedy noted that Dr. Carhart, the plaintiff in both *Stenberg* and *Carhart*, "has made the medical judgment to use the D&X procedure in every case, regardless of indications, after 15 weeks' gestation." *Id.* at 964-65 (Kennedy, J., dissenting). Under the *Stenberg* majority's approach, a "single physician or

group of physicians" has the ability to "set[] abortion policy[,] . . . not the legislature or the people." *Id.* at 965 (Kennedy, J., dissenting). This complete evisceration of the State's legitimate role in determining what procedures are appropriate and which are not – and this substitution of an abortionist's veto for careful, balanced consideration of those interests – is inconsistent with the position outlined in the *Casey* joint opinion. *See Stenberg*, 530 U.S. at 956-57 (Kennedy, J., dissenting) (noting that, under *Casey*, government "retain[s] a critical and legitimate role" in regulating abortion and promoting respect for all human life).

As Petitioner makes clear – and as did the dissenting Justices in *Stenberg* – the record both in *Stenberg* and here establishes that partial-birth abortion is never, truly *medically* necessary. *Id.* at 965-67 (Kennedy, J., dissenting). In any event, courts are simply "ill-equipped to evaluate the relative worth of particular surgical procedures" and substitute their factual determinations for those of the legislature. *Id.* at 968 (Kennedy, J., dissenting). After nearly a decade of robust debate, Congress elected by a wide margin to prohibit partial-birth abortion, in substantial part because the procedure "is never medically indicated to preserve the health of the mother." § 2(14)(O), 117 Stat. 1206. The Constitution does not require this Court to substitute an interested party's *ipse dixit* for the considered, morally serious judgment of the Congress of the United States.

The second, and more basic, way in which this Court has hamstrung legislatures' legitimate right – recognized in *Casey* – to "promote the life of the unborn and to ensure respect for all human life and its potential," *Stenberg*, 530 U.S. at 957 (Kennedy, J., dissenting), has to do not with the "triggering condition" for the "health"-exception requirement, but with the *content* of that requirement.

Again, there is no legitimate *medical* justification for the partial-birth abortion procedure. However, the definition of "health" that was read into the Constitution in *Roe v. Wade* and in *Doe v. Bolton,* and that runs through so much of this Court's post-*Roe* case-law, *is not limited to medical considerations.* In practice, the stylized definition of "health" employed in this Court's abortion cases readily permits a construction and application that winds up requiring states to permit unrestricted abortion on demand, at any time and for any reason. Under *Doe*'s "health"-exception gloss on *Roe,* a woman may – if an abortion provider agrees – secure an abortion (or any method of abortion) for *any* medical-, emotional-, social-, mental- or family-related reason. *Doe,* 410 U.S. at 192. Such a definition – if, indeed, the term can plausibly be "defined" to include so much – permits, in practice, a much more extreme and democracy-blocking notion of the abortion right than the Court seemed to contemplate in *Casey.* Accordingly, this Court should give careful consideration to the definition of "health" in its prior decisions, and overrule or modify *Doe* to the extent that it admits of such an extreme and unreasonable exception to a late-term abortion restriction – an exception that, as *Stenberg* demonstrates, tends to swallow the rule.

The expansion of the definition of "health" started with what the Court in *Roe* and *Doe* held: Under the *Roe / Doe* framework, the right to abortion in the third trimester (that is, "subsequent to viability") may be limited by the state, "except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." *Roe*, 410 U.S. at 164-65. (*Stenberg* cited and quoted this formulation exactly, 530 U.S. at 921.) "Health," however, turns out to be a legal term of art in the abortion context, as was made clear immediately in *Doe.*

In *Doe,* the Court considered whether a recent Georgia statute permitting an abortion where a doctor determines that

it is medically necessary was too narrow or restrictive of the right to abortion recognized in *Roe*. *Doe*, 410 U.S. at 182-83. The Court construed the Georgia exception broadly to embrace broad-ranging discretion for doctors to evaluate anything that might relate, directly or indirectly, to a woman's health, and found the statute constitutional because the health-of-the-mother exception, as so construed, was sufficiently broad to satisfy what the Court felt were the appropriate constitutional standards:

> [T]he medical judgment [of the physician] may be exercised in the light of all factors – physical, emotional, psychological, familial, and the woman's age – relevant to the well-being of the patient. All these factors may relate to health. This allows the attending physician the room he needs to make his best medical judgment. And it is room that operates for the benefit, not the disadvantage, of the pregnant woman.

Doe, 410 U.S. at 192. *Doe*'s description of relevant "health" considerations thus built on *Roe*'s identification of a woman's constitutionally protected interests in having an abortion in order to avoid "a distressful life and future," and its recognition of the "[m]ental and physical health" drains of caring for a child, the "distress, for all concerned, associated with the unwanted child," the "problem of bringing a child into a family already unable, psychologically and otherwise, to care for it," and the "difficulties and continuing stigma" of being an unwed mother. *Roe*, 410 U.S. at 153.

Doe's all-encompassing understanding of health – one that rendered hollow the Court's assurances in that case that a "woman does not have an absolute constitutional right to an abortion on her demand," *Doe*, 410 U.S. at 189 – has carried forward through the Court's abortion case-law (although, of course, *Roe*'s anachronistic "trimester"

framework was discarded in *Casey*). *See, e.g., Stenberg*, 530 U.S. at 930-31 (striking down Nebraska's ban on late-term partial-birth abortions on the ground that the statute did not contain a "health" exception required by *Casey*, *Roe*, and *Doe*). The effect of this understanding of "health" is to vest individual abortionists like Dr. Carhart with the plenary power to overrule any and all restrictions on abortion that a legislature might adopt, even those that apply after the child is viable outside the mother's body. Indeed, the result of this broad *Doe* "health" loophole is to render the purported pre-viability / post-viability line of allowable state regulation of abortion completely illusory. An abortionist may perform essentially any type of abortion he deems appropriate, at any time during pregnancy, for whatever reason the woman and abortionist agree is a sufficient emotional, psychological, or family "health" reason.

It is difficult to believe that this Court meant to embrace such an unrestricted abortionist's veto in *Casey*, in which the majority affirmed the legitimacy and propriety of state regulation to protect fetal human life once the point of viability is reached. *Doe*'s extreme conception of "health," and the carrying forward of such an extreme view in *Stenberg*, is not consistent with the approach of *Casey* and not supportable by the text of the Constitution. In light of *Casey*, the astounding breadth of *Doe*'s "health" loophole is truly a "remnant of abandoned doctrine," *Casey*, 505 U.S. at 855, that this Court should explicitly disapprove. The Court should overrule or modify *Doe*'s health exception to bring the law more faithfully in line with the right of the state, recognized in *Casey*, to restrict or prohibit abortion where the child could live outside his or her mother's womb. *Compare Casey*, 505 U.S. 881-83 (overruling in part *Thornburgh* and *Akron*, on similar grounds).

CONCLUSION

The judgment of the United States Court of Appeals for the Ninth Circuit should be reversed.

Respectfully submitted,

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August 3, 2006

Appendix A

STATEMENTS OF INTEREST OF *AMICI*

The Christian Legal Society ("CLS"), founded in 1961, is a nonprofit interdenominational association of Christian attorneys, law students, judges, and law professors with chapters in nearly every state and most law schools. Since 1975, the Society's legal advocacy division, the Center for Law and Religious Freedom, has litigated and educated on behalf of the sanctity of human life.

The National Association of Evangelicals ("NAE") is a nonprofit association of evangelical Christian denominations, churches, organizations, institutions, and individuals. It includes some 45,000 churches from 59 denominations and serves a constituency of approximately 30 million people. NAE is committed to defending the right to life as a precious gift of God and a vital component of the American heritage.

The Pro-Life Legal Defense Fund, Inc. ("PLLDF") is a Massachusetts not-for-profit corporation that provides pro bono legal services for the protection of human life. The PLLDF strongly opposes the partial-birth abortion procedure.

The Alliance Defense Fund ("ADF") is a nonprofit public interest law firm founded in 1993 to aggressively defend the sanctity of life, religious liberties, and traditional family values. ADF's goal is to reform American law so that all human life will be respected and protected from conception until natural death. To accomplish this goal, ADF has trained hundreds of attorneys to litigate sanctity of life issues. ADF's network of over 700 attorneys has participated in litigation and *amicus curiae* briefs opposing all forms of abortion, including "partial-birth" abortion,

public funding of abortion, and efforts to legalize euthanasia. ADF has also participated in litigation supporting parental consent and informed consent laws, and defending pro-life advocates' free speech rights.

Concerned Women for America ("CWA") is the nation's largest public policy organization for women. Located in Washington, D.C., CWA is a non-profit organization that provides policy analysis to Congress, state and local legislatures and assistance to pro-family organizations through research papers and publications. CWA seeks to inform the news media, the academic community, business leaders and the general public about marriage, family, cultural and constitutional issues that affect the nation. CWA has participated in numerous amicus curiae briefs in the United States Supreme Court, lower federal courts and state courts.

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No. 05-1382

In The
Supreme Court of the United States

ALBERTO R. GONZALES,
ATTORNEY GENERAL,

Petitioner,

ACB (LP)

)OD
A, et al.,

Respondents.

i

To T... United States Court Of Appeals For The Ninth Circuit

MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE* OUT OF TIME AND BRIEF OF THE CHRISTIAN MEDICAL AND DENTAL ASSOCIATIONS AND THE CATHOLIC MEDICAL ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE OUT OF TIME AND BRIEF *AMICI CURIAE*

The Christian Medical and Dental Associations and the Catholic Medical Association move for leave to file the attached *amici curiae* brief, notwithstanding that the time for filing such briefs expired on Thursday, August 3, 2006. This extension is justified by the fact that counsel for *amici curiae* was hospitalized on an emergency basis on the morning of August 1, 2006.

Counsel for *amici curiae* has pursued the preparation of this brief with diligence. Counsel for the parties have been served electronically on August 8, 2006 to minimize delay in providing them access to the arguments asserted in the brief. The parties have consented to the filing of this brief.

Respectfully submitted,

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INTEREST OF THE *AMICI CURIAE*[1]

Amici Curiae The Christian Medical & Dental Associations were founded in 1931 and today represents over 17,000 members – primarily practicing physicians representing the entire range of medical specialties. This organizations view principles of biblical faith as essential to protecting the lives and best interests of patients, the conscientious practice of medicine according to long-standing Hippocratic and religious principles, and to preserving the public respect accorded to physicians as guardians of health and life.

Amicus Curiae Catholic Medical Association is an association of physicians who agree with the United States Conference of Catholic Bishops in their observation that:

> Modern medicine has brought us face-to-face with the continuum of human life from conception onwards, and the inescapable reality of human life in the womb. Yet our legal system, and thus our national culture, is being pressed to declare that human life has no inherent worth, that the value of human life can be assigned by the powerful and that the protection of the vulnerable is subject to the arbitrary choice of others. The lives of all who are marginalized by our society are endangered by such a trend.[2]

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[1] Letters of consent have been filed with the Clerk. None of the counsel for the parties authored this brief in whole or in part, and no one other than *amici* or its counsel has contributed money or services to the preparation or submission of this brief.

[2] Nat'l Conference of Catholic Bishops, *Abortion and the Supreme Court* (Nov. 15, 2000).

The practice of partial-birth abortion further advances this perilous trend and is never medically necessary.

SUMMARY OF ARGUMENT

Respondents as non-physicians are not subject to any penalty under the Partial-Birth Abortion Act of 2003 ("Act"), and therefore have not presented an actual case or controversy for adjudication. The advisory opinions rendered below exceed the Article III jurisdiction of those courts, expanding this Court's jurisprudence of associational and third party standing beyond any possible limitation. Moreover, notwithstanding the plain language of the Act which limits its reach to physicians, the record fails to establish any imminent or actual injury suffered by Respondents permitting them to seek review of the Act. Absent standing, the Respondents may not assert standing on behalf of women who may seek abortions beyond the first trimester of their pregnancies.

In the event this Court determines that Respondents have established standing to challenge the Act, the district court erred in finding that the Act imposed an undue burden on the right of women to obtain an abortion since only a tiny fraction of the relevant group of women seeking abortions will obtain D & X abortions contrary to the provisions of the Act.

ARGUMENT

I. RESPONDENTS HAVE NO STANDING BECAUSE THE ACT DOES NOT APPLY TO NON-PHYSICIANS.

Courts have a "deeply rooted" commitment "not to pass on questions of constitutionality" unless adjudication of the constitutional issue is necessary, *Spector Motor Service, Inc. v. McLaughlin,* 323 U.S. 101, 105 (1944). In every federal case, the party bringing suit must establish standing to prosecute the action. The importance of vigilantly enforcing the standing requirements is well described in *Valley Forge Christian College v. Americans United for Separation of Church and State, Inc.,* 454 U.S. 464 (1982).

> The exercise of the judicial power also affects relationships between the coequal arms of the National Government. The effect is, of course, most vivid when a federal court declares unconstitutional an act of the Legislative or Executive Branch. While the exercise of that "ultimate and supreme function," *Chicago & Grand Trunk R. Co. v. Wellman, supra,* at 345, 12 S.Ct., at 402, is a formidable means of vindicating individual rights, when employed unwisely or unnecessarily it is also the ultimate threat to the continued effectiveness of the federal courts in performing that role. While the propriety of such action by a federal court has been recognized since *Marbury v. Madison,* 1 Cranch 137, 2 L.Ed. 60 (1803), it has been recognized as a tool of last resort on the part of the federal judiciary throughout its nearly 200 years of existence:
>
> > "[R]epeated and essentially head-on confrontations between the life-tenured

Constitutional government raised by this case require that this Court exercise the "passive virtue"[3] of rejecting this case for a lack of Article III standing. Such a rejection does not leave the Act beyond judicial review as evidenced by *Gonzales v. Carhart*, No. 05-380 presently pending before this Court. The judgment of the lower courts should be reversed, and this case dismissed.

Standing is "an essential and unchanging part of the case-or-controversy requirement of Article III." *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992). "In essence the question of standing is whether the litigant is entitled to have the court decide the merits of the dispute or of particular issues." *Warth v. Seldin*, 422 U.S. 490, 498 (1975). "Only those to whom a statute applies and who are adversely affected by it can draw in question its constitutional validity in a declaratory judgment proceeding as in any other." *Alabama State Federation of Labor v. McAdory*, 325 U.S. 450, 463 (1945).

In the instant case, none of the Respondents are subject to penalty under the Act, which by its terms applies only to the conduct of physicians. See 18 U.S.C. § 1531(a). Neither the original plaintiffs, Planned Parenthood Federation of America and Planned Parenthood Golden Gate, nor intervenor, the City and County of San Francisco, are physicians as defined by the Act.

> [T]he term "physician" means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the

---

[3] See Alexander M. Bickel, THE LEAST DANGEROUS BRANCH 111-98 (1962).

> doctor performs such activity, or any other individual legally authorized by the State to perform abortion: *Provided, however,* That any individual who is not a physician or not otherwise legally authorized by the State to perform abortions, but who nevertheless directly performs a partial-birth abortion, shall be subject to the provisions of this section.

18 U.S.C. § 1531(b)(2). Only physicians are permitted to perform surgical abortions under California law (Cal. Bus. & Prof. Code § 2253(b)(1)), and only natural persons are eligible to be physicians in California. Cal. Bus. & Prof. Code § 2032. *See also Lathrop v. Healthcare Partners Medical Group*, 8 Cal. Rptr. 3d. 668, 673 (1st Dist. 2004).

"It is a long-settled principle that standing cannot be 'inferred argumentatively from averments in the pleadings,' but rather 'must affirmatively appear in the record.'" *FW/PBS, Inc. v. City of Dallas*, 493 U.S. 215, 231 (1990). The record below fails to establish the standing of any of the Respondents to challenge the Act. Planned Parenthood Federation of America ("PPFA") does not provide any medical services. *See* Tr. 130-31 (Craig). Planned Parenthood Golden Gate ("PPGG") alleged it "employs and/or contracts with physicians who perform second-trimester abortion procedures that may fall within the proscriptions of the Act, including D&E abortions." (ER at 11:21-22). However, according to the most recent IRS Form 990 available for PPGG, the clinic employs only "contract physicians." Planned Parenthood Golden Gate, IRS Form 990 (2004), at 37 (available at http://www.guidestar.org/FinDocuments/2005/946/138/2005-946138828-022cbd02-9.pdf). The City and County of San Francisco ("San Francisco") made no allegations regarding any legal relationships to physicians who perform abortions. The only allegation

made regarding abortion was that "San Francisco General Hospital Women's Options Center ("Center") provides second-trimester abortions and accepts patients regardless of the ability to pay." *Planned Parenthood Federation of America, et al. v. Ashcroft, Complaint in Intervention* 2003 WL 23109226 ¶7 (N.D. Cal. 2003). This allegation, however, is not sufficient to create standing to challenge the Act, since the Center *qua* Center does not perform abortions, nor does it employ the physicians who perform the abortions. *See* Tr. 277 (Drey) (listing head nurse, counselor, and research assistance as employees). Abortions are performed by the faculty and students of the University of California San Francisco Medical School, who provide their services pursuant to a contract with the Public Health Department of San Francisco. *Report of the 2001-2002 San Francisco Civil Grand Jury, San Francisco General Hospital* at 4 (Sup. Ct. Cal., 2002) ("SFGH is staffed with physicians from UCSF [University of California San Francisco]. In return, SFGH provides research opportunities and facilities to UCSF physicians/researchers at the SFGH campus.") available at http://www.sfgov.org/site/uploadedfiles/courts/SFGHreport(3).pdf (last viewed August 2, 2006). There is no evidence in the record of any direct involvement of San Francisco in the performance of abortions.

Neither the original plaintiffs, nor San Francisco are subject to any penalty under the Act, yet they demand this Court invalidate the Congressional ban of what even defenders characterize as a "gruesome" procedure. *See Stenberg v. Carhart*, 530 U.S. 914 at 946 (2000) (Stevens, J. concurring). Respondents are simply no more than "concerned bystanders" seeking "a vehicle for the vindication of [their] value interests." *Cf. Valley Forge Christian College v. Americans United for Separation of Church and*

State, Inc., 454 U.S. 464, 473 (1982). The judgment of the lower courts should be reversed, and the case dismissed because the Respondents lack standing.

II. RESPONDENTS HAVE FAILED TO SHOW A THREAT OF "ACTUAL OR IMMINENT" INJURY.

The "irreducible constitutional minimum of standing contains three elements": (1) A concrete injury (2) that is traceable to the defendant's conduct and (3) that will be redressed by a court order. *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560 (1992). A plaintiff's injury must be "an invasion of a legally-protected interest which is (a) concrete and particularized, and (b) 'actual or imminent, not "conjectural" or "hypothetical"'." *Id.* at 560-61 (citations omitted). Respondents have failed to make the necessary showing of any concrete injury from the Act. Rather the record reveals that their case is merely "conjectural" or "hypothetical."

The chain of contingencies that must occur before a concrete injury will be suffered by any of the Respondents include: 1) a woman must become pregnant, 2) allow the pregnancy to progress beyond the first trimester, 3) decide to terminate the pregnancy, 4) seek the assistance of a physician associated with one of the Respondents in terminating the pregnancy, 5) either be unaware of or reject the opportunity to have fetal demise induced prior to removal of the fētus, 6) be provided a partial-birth abortion as defined in the Act, 7) have a United States Attorney seek to impose criminal liability on one of the Respondents, notwithstanding the clear language of the Act limiting its applicability to "physicians" or those individuals "who nevertheless directly performs a partial-birth abortion." *See* 18 U.S.C. § 1531(b)(2).

The average American woman will experience 3.2 pregnancies in her lifetime.[4] These pregnancies will result in 2.1 live births, and 0.7 induced abortions on average.[5] Stillbirths and miscarriages comprise the balance of these experiences.[6] The vast majority of women who seek abortions will terminate their pregnancies in the first trimester using procedures not at issue in this litigation. *Planned Parenthood Federation of America v. Ashcroft*, 320 F.Supp. 2d 957, 960 (2004). Of the approximately fifteen percent who decide to terminate their pregnancies after the first trimester (*id.*), some will request that their physicians induce fetal demise before the abortion, and thus their physicians' actions will clearly be excluded from the terms of the Act. 320 F.Supp. 2d 957, 962 and 995-97. Of the women who choose to terminate their pregnancies after the first trimester without fetal demise being induced prior to removal of the fetus by induction or D&E, some will choose to use the services of physicians not associated with the Respondents. Of the remaining women who choose to terminate their pregnancies after the first trimester without fetal demise having been induced prior to removal of the fetus using the services of a physician associated with the Respondents, the abortion would have to be performed in a manner that would violate the Act. Finally, the U.S. Attorney would have to bring suit and

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[4] Stephanie J. Ventura et al., *Estimated Pregnancy for the United States, 1990-2000: An Update*, 52 Nat'l Vital Stat. Rpts. No. 23 at 8 (June 15, 2004) at http://www.cdc.gov/nchs/data/nvsr/nvsr52/nvsr52_23.pdf.

[5] *Id.*

[6] Stephanie J. Ventura et al., *Highlights of Trends in Pregnancies and Pregnancy Rates by Outcome: Estimates for the United States, 1976-96*, 47 Nat'l Vital Stat. Rpts. No. 29 at 3 (Dec. 15, 1999) at http://www.cdc.gov/nchs/data/nvsr/nvsr47/nvs47_29.pdf.

persuade the courts that the Act applies to one of the Respondents as non-physicians under some creative theory of liability.

This outline of the requisite chain of events makes clear the speculative nature of the Respondents' injury. This deficiency is not cured by Respondents' inclusion of claims on behalf of their patients in light of the exemption of patients from any claims of conspiracy under the Act. See 18 U.S.C. § 1531(e).This chain of speculative occurrences is much too weak to support Respondents' standing for Article III purposes.

III. RESPONDENTS MAY NOT ASSERT THE RIGHTS OF PHYSICIANS SINCE DOCTORS ARE NOT HINDERED FROM ASSERTING THEIR LEGAL RIGHTS.

As a general rule, a party "must assert his own legal rights and interests, and cannot rest his claim to relief on the legal rights or interests of third parties." *Warth v. Seldin*, 422 U.S. at 499. However, others may litigate the rights of third parties in those rare cases where the original party has standing, and there is a close relationship between the party asserting the right and the party possessing the right, plus the party possessing the right is hindered from protecting his own interests. *Kowalski v. Tesmer*, ___ U.S. ___, 125 S.Ct. 564, 576 (2004) (rejecting third-party standing of attorneys on behalf of prospective clients).

Inherent in Respondents' challenge is a dangerous expansion of the law governing standing to assert facial challenges. Abortion jurisprudence reveals cases of physicians, either alone or in conjunction with others (including

clinics), asserting the rights of doctors and their patients. *E.g., Doe v. Bolton*, 410 U.S. 173, 188 (1973); *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 62 (1976); *Singleton v. Wulff*, 428 U.S. 106, 109 (1973); *Colautti v. Franklin*, 439 U.S. 379, 383 n. 3 (1979); *Bellotti v. Baird*, 443 U.S. 622, 626 (1979); *Williams v. Zbaraz*, 448 U.S. 358, 361 (1980); *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 440 n. 30 (1983); *Planned Parenthood Ass'n of Kansas City, Mo., Inc. v. Ashcroft*, 462 U.S. 476, 478 (1983); *Simopoulos v. Virginia*, 462 U.S. 506 (1983); *Webster v. Reproductive Health Services*, 492 U.S. 490, 502 (1989); *Hodgson v. Minnesota*, 497 U.S. 417, 429 (1990); *Rust v. Sullivan*, 500 U.S. 173, 181 (1991); *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 845 (1992) (plurality); *Lambert v. Wicklund*, 520 U.S. 292, 294 (1997); *Mazurek v. Armstrong*, 520 U.S. 968, 970 (1997) (per curiam); and *Stenberg v. Carhart*, 530 U.S. 914, 922 (2000).

This Court has also recognized the standing of abortion clinics alone to bring cases vindicating the rights of the clinic *qua* clinic. *See, e.g., Madsen v. Women's Health Center*, 512 U.S. 753, 757 (1994) (conflict between abortion protesters and clinic operators).

However, what does not exist, and cannot exist under the case or controversy requirement of Article III of the Constitution, is a case where organizations have successfully sought review of a federal statute that by its terms can not be applied to them. To accept Respondents' position is to *sub silencio* reverse the centuries of this Court's jurisprudence barring advisory opinions – something which this Court has refused to do since the founding of the nation. See *Vieth v. Jubelirer*, 541 U.S. 267, 302 (2004).

IV. OVERBREADTH ANALYSIS SHOULD NOT BE APPLIED TO THE ACT.

Facial challenges to the constitutionality of statutes are generally disfavored, and the claim that statutes are constitutionally overboard is available in very few circumstances.

> A facial challenge to a legislative Act is, of course, the most difficult challenge to mount successfully, since the challenger must establish that *no set of circumstances* exists under which the Act would be valid. The fact that the . . . Act might operate unconstitutionally under some conceivable set of circumstances is insufficient to render it wholly invalid, since we have not recognized an "overbreadth" doctrine outside the limited context of the First Amendment.

United States v. Salerno, 481 U.S. 739, 745 (1987) (emphasis added). This "no set of circumstances" test (*Salerno* test) is the test that is generally applied to any facial challenge to the constitutionality of a statute.

In *Rust v. Sullivan*, 500 U.S. 173 (1991) the Court applied the *Salerno* test to determine the constitutionality of federal regulations regarding abortion. Recipients of family planning funds under Title X sued the Department of Health and Human Services (HHS), claiming that the prohibition contained in Title X for use of funds for projects engaged in abortion counseling, referral, and activities advocating abortion as a method of family planning was unconstitutional. *Id.* at 181. In rejecting the challenge, this Court held that the recipients had not shown that there were no circumstances under which the statute could be applied constitutionally. Therefore they had failed

to overcome the burdens of a facial challenge to a legislative Act as defined in *Salerno*. *Id.* at 183, 203. As in *Rust*, Respondents have not met the burden established by *Salerno*.

Attempting to evade this stringent standard, Respondents seek to invoke the overbreadth doctrine as a means of challenging the Act. The overbreadth doctrine has been largely limited to First Amendment challenges because of the unique role free speech plays in preserving our constitutional system of government. *See e.g. New York Times Co. v. United States*, 403 U.S. 713 (1971) and Alexander Meiklejohn, FREE SPEECH AND ITS RELATION TO SELF-GOVERNMENT 24-27 (1948).

Abortion, particularly the procedure known as partial-birth or D & X abortion, plays no similar role in preserving the constitutional order and warrants no special solicitude by this Court. The application of overbreadth analysis to abortion regulation has been expressly rejected by this Court in *Ohio v. Akron Center for Reproductive Health*, 497 U.S. 502, 514 (1990) and *Rust v. Sullivan*, 500 U.S. 173, 183 (1991). *But see Sabri v. U.S.*, 541 U.S. 600, 610 (2004) (dicta characterizing *Stenberg v. Carhart*, 530 U.S. 914 (2000) as applying the overbreadth doctrine).

Overbreadth analysis is also foreclosed because the Act contains criminal sanctions. "[O]utside the limited First Amendment context, a criminal statute may not be attacked as overbroad." *Schall v. Martin*, 467 U.S. 253, 268, n. 18 (1984) (detaining juveniles under the New York Family Court Act was found to not be a violation of the due process clause).

V. THE ACT DOES NOT IMPOSE AN UNDUE BURDEN ON RESPONDENTS OR THEIR PATIENTS.

Guided by the standard articulated in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 303 (1992), the lower court found that the Act imposed "an undue burden on women's right to choose a previability abortion." *Planned Parenthood Federation v. Gonzales*, 435 F.3d 1163, 1176 (2006). However, proper application of the *Casey* standard supports the constitutionality of the Act. In *Casey,* Pennsylvania had erred in defining the breadth of the class that was covered under the Omnibus Abortion Control Act at issue. The state defined the affected class as those women seeking abortions and presented evidence that only one percent of those women would be affected by the Act. *Casey*, 505 U.S. at 894. However, Justice O'Connor held that the class was narrower because it included only "married women seeking abortions who do not wish to notify their husbands of their intentions and who do not qualify for one of the statutory exceptions to the notice requirement." *Id.* Therefore, this Court found that a substantial fraction of the redefined class was injured by the spousal notification provision of the Act.

In the current case, Respondents have defined the relevant class as all employees, staff, servants, officers, agents, current and future physicians, medical residents, faculty supervisors, and patients involved with abortions. Compl. ¶ 9. Respondents' interest in this case relies on a class which is broader than that found in *Casey*. Overall, the *Casey* Court had a narrow class, with a clearly defined injury, and a particularized causal link between the state

and physicians before it. *Casey* at 893. In contrast, Respondents have presented this Court with a broad class, a purely hypothetical injury, and an attenuated causal link between themselves and the Attorney General of the United States. A correct application of the *Casey* standard supports the constitutionality of the Act.

VI. ANY RULING OF UNCONSTITUTIONALITY SHOULD BE LIMITED IN SCOPE.

This Court recently stated in *Ayotte v. Planned Parenthood of Northern New England*, ___ U.S. ___, 126 S.Ct. 961 (2006) (citations omitted) that "[w]e prefer, for example, to enjoin only the unconstitutional applications of a statute while leaving other applications in force or to sever its problematic portions while leaving the remainder intact." *Id.* at 967. Three reasons were given for applying the above principle:

> First, we try not to nullify more of a legislature's work than is necessary, for we know that a ruling of unconstitutionality frustrates the intent of the elected representatives of the people. Second, mindful that our constitutional mandate and institutional competence are limited, we restrain ourselves from rewriting state law to conform it to constitutional requirements even as we strive to salvage it. Third, *the touchstone for any decision about remedy is legislative intent*, for a court cannot use its remedial powers to circumvent the intent of the legislature.

Id. (citations omitted) (emphasis added).

The intent of Congress in passing the Act was to prevent the medical community from moving dangerously close to practicing infanticide. Pub. L. No. 108-105,

§ 2(14)(G), 117 Stat. 1201 (2003). It is the D & X procedure, not the D & E procedure that Congress intended to criminalize. "[I]ntact D & X is aberrant and troubling because the technique confuses the disparate role of a physician in childbirth and abortion in such a way as to blur the medical, legal, and ethical line between infanticide and abortion." *Stenberg* at 963. As Justice Kennedy noted, "States have interests including concern for the life of the unborn and 'for the partially-born,' in preserving the integrity of the medical profession, and in 'erecting a barrier to infanticide.'" *Stenberg* at 961.

It is these concerns that Congress intended to address. If this Court finds that there is unconstitutional ambiguity within the terms of the Act then only those applications that are unconstitutional should be enjoined. "Virtually all statutes have some 'conceivable' unconstitutional applications, but even the most adamant proponent of overbreadth doctrine would not suggest that these conceivable applications alone provide a sufficient basis for a statute's facial invalidation."[7] As in *Ayotte*, this Court can either remand the case for clarification by the lower court or clarify the ambiguity about D & X while maintaining the intent of Congress which is the touchstone for crafting the remedy.

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[7] Michael C. Dorf, *Facial Challenges to State and Federal Statutes*, 46 Stan. L. Rev. 235, 273 (1994) (discussing basic canon of constitutional adjudication).

CONCLUSION

For the foregoing reasons, *amici curiae* respectfully request that this Court reverse the judgments of the lower courts.

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IN THE

Supreme Court of the United States

ALBERTO R. GONZALES, ATTORNEY GENERAL,
Petitioner,

—v.—

LEROY CARHART, ET AL.,
Respondents.

ALBERTO R. GONZALES, ATTORNEY GENERAL,
Petitioner,

—v.—

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., ET AL.,
Respondents.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT AND THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF OF *AMICI CURIAE* STATISTICIANS PROFESSOR GEORGE W. COBB, PROFESSOR MARY W. GRAY, PROFESSOR NORMAN HENDERSON, PROFESSOR JOHN J. MCARDLE, PROFESSOR JAMES TRUSSELL, AND PROFESSOR JEFFREY A. WITMER IN SUPPORT OF RESPONDENTS

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INTEREST OF *AMICI CURIAE*[1]

Amici curiae are professors at prominent universities and colleges, as well as distinguished statisticians in their fields. Even with the breadth of their professional interests, *amici* are united in their belief that statistical analysis used in judicial decision-making must rest on sound scientific principles. *Amici* are aware that the interpretation of scientific data often plays a role in courts' adjudication of facts and law. Absent professional guidance, courts may misapply statistical principles and render decisions based, at least in part, on invalid or unsupportable assumptions.

Amici believe that portions of the record below reflect a misapplication of sound statistical methodology. Misleading and incorrect statements by some of the government's expert witnesses were relied upon by two of the district courts, and have been perpetuated in briefs submitted to this Court by Petitioner and supporting *amici*. *Amici* here believe that correcting those misleading and incorrect assertions, and providing an accurate interpretation of the data upon which those assertions purport to rely, will contribute to the Court's understanding and help it reach a well-reasoned, scientifically-principled decision in these highly important appeals.

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[1] Pursuant to Supreme Court Rule 37, *amici curiae* state that this brief has not been authored in whole or in part by counsel for a party in this case, and no entity other than the *amici* or their counsel made a monetary contribution to the preparation or submission of this brief. Letters of consent to the filing of this brief have been lodged with the Clerk.

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INTRODUCTION AND SUMMARY OF ARGUMENT

The relative safety of intact dilation and extraction ("intact D&X") compared to dilation and evacuation by disarticulation ("D&E") is a critical question in the scientific debate surrounding the Partial-Birth Abortion Ban Act of 2003, which all parties agree prohibits, at a minimum, intact D&X. At the center of this debate is a peer-reviewed study by Dr. Stephen T. Chasen and colleagues, which compared the complication rates of intact D&X and D&E in a group of 383 women who received these procedures at The New York Weill Cornell Medical Center. The study authors found the comparative complication rates of the two procedures to be similar, suggesting that women undergoing intact D&X face no increased risk compared to those undergoing D&E. Stephen T. Chasen *et al.*, *Dilation and evacuation at ≥ 20 weeks: comparison of operative techniques*, 190 Am. J. Obstet. Gynecol. 1180 (2004) (the "Chasen study") (attached as Appendix A).[2]

The Chasen study was the subject of extensive expert witness testimony in the trial court records in Nebraska, New York, and California, where several of the government's experts incorrectly asserted, with varying degrees of certitude, that portions of the data show that intact D&X may be riskier than D&E. *Amici* believe those statements were misleading because the numerical differences upon which they were based are not "significant" as measured by

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[2] *Amici* use the term "intact D&X," as opposed to "intact D&E" or simply "D&X," to reflect the term Dr. Chasen used in his published study. *See* Chasen, *Dilation and evacuation, supra,* at 1180-83.

accepted methods of statistical analysis. Those misstatements were incorrectly relied upon by some of the lower courts and now reappear in briefs submitted to this Court. *Amici* believe it is critical to ensure that the Court has a scientifically accurate understanding of the Chasen study and the conclusions about the relative risk of intact D&X and D&E that can, and cannot, validly be drawn from its data.

At the root of the government experts' misstatements is the meaning of the statistical concept of probability value (or "p-value"), which measures the statistical significance of observed differences in outcomes among members of a group. *Amici* therefore seek to do the following: (1) provide the Court with an accurate description of the concept of p-value; (2) explain why the relevant p-values in the Chasen study are not statistically significant and therefore do not support the assertions of the government's experts that intact D&X may be more risky than D&E; and (3) highlight additional statistical evidence from a follow-up study published by Dr. Chasen that further undermines those experts' assertions.

SUMMARY OF THE CHASEN STUDY

The objective of the Chasen study, published in the peer-reviewed *American Journal of Obstetrics and Gynecology* in 2004, was "to evaluate the relative safety of dilation and evacuation and intact D&X in patients undergoing surgical abortion late in the second trimester." Chasen, *Dilation and evacuation, supra,* at 1181. Prior to the publication of the Chasen study, no data had been formally published regarding the complication rates of intact D&X. Dr. Chasen sought to collect data on the complications that resulted from intact D&X and D&E in order to assess whether intact D&X posed a greater health risk than D&E.

Dr. Chasen's study sample included a group of 383 women who underwent either intact D&X or D&E at twenty weeks' gestation or greater at The New York Weill Cornell Medical Center between June 1996 and June 2003. Dr. Chasen retrospectively identified cases for inclusion in the study sample by reviewing operative reports to determine the extraction technique used. Of the 383 women included in the study, 120 (31.3%) received intact D&X and 263 (68.7%) received D&E. Dr. Chasen used this sample to assess whether there was any difference between the two surgical variations in the number or severity of operative and post-operative complications. "Complications" was defined in the study as "any situation requiring unplanned intervention," including "unplanned hospital admission, repair of any genital tract lacerations, return to the operating room for additional procedures, and blood transfusion." *Id.* at 1181.

Dr. Chasen also identified a smaller sample of 62 women from among the larger group of 383 who later became pregnant and sought prenatal care at The New York

Weill Cornell Medical Center. Of those 62 women, 17 had originally undergone intact D&X and 45 had originally undergone D&E. Dr. Chasen used this sample to assess whether there was any difference between the two surgical variations in subsequent adverse pregnancy outcomes. Specifically, Dr. Chasen examined the incidence of spontaneous preterm birth, which occurs when a woman unexpectedly delivers prematurely in the third trimester before the fetus has been carried to term.

Dr. Chasen found that operative and post-operative complications "occurred with similar frequency" in the two patient groups—5.0% (6 out of 120) of the intact D&X group compared to 4.9% (13 out of 263) of the D&E group. *Id.* at 1182. With regard to subsequent pregnancy outcomes, Dr. Chasen found that 11.8% (2 out of 17) of the intact D&X group and 4.4% (2 out of 45) of the D&E group experienced spontaneous preterm birth in a later pregnancy. The percentage difference in the incidence of subsequent preterm birth, however, was not statistically significant when measured by a p-value calculation, the established method of assessing the statistical significance of different outcomes. Specifically, the p-value calculation of 0.30 was far greater than 0.05, the threshold at or below which an observed difference is deemed statistically significant. Dr. Chasen ultimately concluded, based on these data, that "intact D&X appears to have similar complication rates as dilation and evacuation" and that "[t]he observed complication rates and subsequent obstetric outcomes appear comparable between the 2 techniques." *Id.* at 1183.

ARGUMENT

I. Testimony That Intact D&X Patients In The Chasen Study Showed An Increased Risk of Subsequent Preterm Birth Is Inaccurate And Should Be Disregarded.

In his testimony about the Chasen study before Judge Casey in the Southern District of New York, one of the government's expert witnesses, Dr. Steven L. Clark, ascribed a false significance to the numerical difference in the incidence of subsequent preterm birth in the intact D&X group versus the D&E group. Dr. Clark did this in two ways. First, he asserted that patients who received intact D&X showed a "threefold increased risk of premature birth," N.Y. Tr. 2386:4-2386:13, even though the numerical difference between the two groups was not statistically significant. One cannot validly conclude from these data that patients undergoing intact D&X have an increased risk of subsequent preterm birth compared to patients undergoing D&E. Second, Dr. Clark compounded his error by asserting that the 0.30 p-value in the Chasen study indicated a 70% chance that there was in fact a true difference between intact D&X and D&E in the likelihood of causing subsequent preterm births. N.Y. Tr. 2425:15-2426:18. Such an assertion fundamentally misstates the conclusions that can be drawn from a p-value calculation. A p-value helps one evaluate whether an observed difference is statistically significant; it does not indicate the probability that there is a true difference between two groups.

Dr. Clark's misstatements about the Chasen study data, p-value calculations, and statistical significance persist in the record before this Court. For example, although Judge Casey

struck down the Partial-Birth Abortion Ban Act, he mistakenly endorsed Dr. Clark's testimony in his opinion. *See Nat'l Abortion Fed'n ("NAF") v. Ashcroft*, 330 F. Supp. 2d 436, 476-77 (S.D.N.Y. 2004). The Solicitor General, in his brief to this Court in *Gonzales v. Carhart*, reiterates Dr. Clark's misleading assertion that the Chasen study "showed a nearly threefold increase in the risk of premature birth" in women who had undergone intact D&X, without mentioning the lack of statistical significance of those data. Petr.'s Br. (*Carhart*) 38 n.12. Similarly, the *amicus* brief filed by the American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG) *et al.* cites Dr. Clark's testimony about the supposed "threefold increased risk of premature birth" as evidence of the "possible dangers of D&X." Br. of *Amici Curiae* AAPLOG *et al.* 19-20.

Because these assertions disregard well-settled statistical principles for interpreting data, or worse, fundamentally misstate those principles, *amici* seek to provide the Court with an accurate explanation of the meaning of a p-value calculation and to explain from a statistical standpoint why the Chasen study data do not support the conclusion that intact D&X causes more complications than D&E in subsequent pregnancies.

A. It Is Widely Accepted In The Scientific Community That An Observed Difference Between Two Groups Is Statistically Significant Only When The P-value Equals 0.05 Or Less.

The Chasen study was designed to evaluate the relative safety of intact D&X and D&E by examining data from a sample of patients who received one or the other of these two surgical variations. In any study that seeks to draw a conclusion about the population as a whole from a smaller

sample, it is necessary to determine whether any differences observed in the sample are "statistically significant." If the differences are not "statistically significant," it is more likely that they reflect variation due to chance. Only when observed differences have been determined to be "statistically significant" may these differences validly be attributed to the general population. Statisticians perform this analysis by calculating a probability value (or "p-value"), which accounts for factors such as a small sample size and a small number of events that might skew the observed data and suggest a false difference.

To use a straightforward example, suppose we wish to compare how often a certain penny and a certain nickel turn up "heads." We begin by forming what is called a "null hypothesis"—a hypothesis that there is no difference between the frequency with which the penny will turn up heads and the frequency with which the nickel will turn up heads. We then test the null hypothesis by flipping each coin repeatedly and counting the number of times that each coin turns up heads. Suppose we flip each coin 5 times and find that the penny turns up heads in 4 of the 5 flips (or 80% of the time) and the nickel turns up heads in 2 of the 5 flips (or 40% of the time). Even though the observed frequencies clearly differ numerically, it would be a mistake to reject the null hypothesis based on these limited data and conclude that the penny is twice as likely as the nickel to turn up heads. The number of flips is too small for us to question seriously the null hypothesis. It is entirely plausible that we would observe 4 out of 5 heads when tossing a "fair" penny and 2 out of 5 heads when tossing a "fair" nickel simply by chance. In contrast, we would feel more confident about rejecting the null hypothesis, and concluding that the penny and the nickel are in fact different, if we flipped the coins 5,000 times each

and found that the penny turned up heads 4,000 times while the nickel turned up heads 2,000 times.

Statisticians formally compare observed data with the null hypothesis by calculating a p-value; ultimately, it is the p-value that determines whether the null hypothesis will be rejected. Statisticians calculate a p-value by first assuming that the null hypothesis is true—that there is actually no difference in the frequency with which the penny will turn up heads and the frequency with which the nickel will turn up heads. Given this assumption, a p-value then measures the probability that we would see a difference in the sample similar to or greater than the difference we actually observed. To return to the coin flip example, a p-value measures the likelihood that the difference we observed—that is, the difference in the number of heads that turned up for the penny versus the nickel—or an even greater difference, would in fact occur, assuming there was no *true* difference between them. In doing so, a p-value accounts for the distortion caused by the small number of flips for each coin.

It is generally accepted within the scientific community that an observed difference between two outcomes is significant only if the p-value is less than or equal to 0.05.[3] A p-value at or below the 0.05 threshold indicates that if there is no true difference in the population, the likelihood of observing the difference we observed in our sample is small—only 5%. If the probability of observing such a

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[3] A p-value of 0.05 is the broadest cut-off for statistical significance recognized by the scientific community. Designation of more restrictive p-value thresholds of 0.01 or even 0.001 as indicators of stronger statistical significance is also generally accepted.

difference is that low or lower, it is very unlikely that the observed difference can be explained by chance. At that point, statisticians feel comfortable rejecting the null hypothesis and concluding that there is a "statistically significant" difference between the two outcomes. A p-value greater than 0.05, on the other hand, indicates sufficient possibility that the observed difference was due to chance that it would be inappropriate to reject the null hypothesis and conclude that the difference was significant. This statistical convention is well-settled and uncontroversial. *See* David H. Kaye & David A. Freedman, *Reference Guide on Statistics, in Fed. Judicial Ctr., Reference Manual on Scientific Evidence* 83, 121-125 (2d ed. 2000). Indeed, the government's experts, including Dr. Clark, did not contest this point in their testimony. *See* N.Y. Tr. 2425:15-2425:17 (Clark); N.Y. Tr. 2197:8-2197:10 (Sprang); Neb. Tr. 1721:18-1722:8 (Lockwood).

In the context of the Chasen study, p-value calculations help to assess whether any differences between intact D&X and D&E observed in the study sample were likely due to chance or were significant enough for one validly to conclude that a similar difference would likely occur in the general population of all women undergoing intact D&X and D&E. Only a p-value of 0.05 or less would support the latter conclusion.

B. The Chasen Study Found No Statistically Significant Difference In The Incidence Of Subsequent Preterm Birth Between The Intact D&X Group And The D&E Group Based On A P-value Of 0.30.

Because the Chasen study data pertaining to differences in subsequent preterm birth rates between the intact D&X

and D&E groups is not statistically significant, it is inaccurate to conclude, as Dr. Clark did, that intact D&X showed a "threefold increased risk" in subsequent preterm birth compared to D&E. N.Y. Tr. 2386:10. Dr. Clark focused solely on the *numerical* difference in the percentage of patients who experienced subsequent preterm births in the intact D&X group compared to the D&E group. He did not take into account the effect of the small number of events and the relatively small sample size that, in this case, renders the numerical difference statistically inconsequential. In sum, Dr. Clark's assessment of the data disregards the importance of p-value.

To be sure, the raw numbers show that the patients who received intact D&X experienced a higher rate of subsequent preterm births than those who received D&E. Out of a total of four preterm births, two occurred in each patient group. This translates to an event rate of 11.8% (2 out of 17 patients) in the intact D&X group versus 4.4% (2 out of 45 patients) in the D&E group, a roughly threefold difference. The numerical comparison of these event rates, however, is only the beginning of the analysis. To draw any valid scientific conclusion from these data about the relative risk of preterm birth from undergoing intact D&X versus D&E, it is necessary to evaluate how likely it is that the observed difference between the two groups is an accurate representation of what would occur in the broader population of women undergoing these procedures. In other words, one must determine whether the threefold numerical difference observed in the Chasen study would likely replicate itself in a larger sample, or whether, as in the coin flip example, the observed difference is easily explained by chance.

Dr. Chasen appropriately considered this question in his study by calculating a p-value to determine whether the observed difference in preterm births was significant. The resulting p-value of 0.30 falls well above the recognized threshold for statistical significance of 0.05 or less, indicating that there is enough of a possibility that the difference was caused by chance that it would be invalid to conclude that there is increased risk for the intact D&X group. Dr. Chasen correctly determined that the difference was insignificant and thus concluded that the "subsequent obstetric outcomes appear comparable between the 2 techniques." Chasen, *Dilation and evacuation*, *supra*, at 1183.

Dr. Charles Lockwood, the Chairman of the Department of Obstetrics, Gynecology and Reproductive Sciences at Yale University and one of the government's expert witnesses, agreed that these data lacked significance and could not validly support a conclusion that intact D&X subjected women to increased risk in later pregnancies. With regard to the difference in subsequent preterm births, Dr. Lockwood testified:

> It's not statistically significant, so I wouldn't . . . put an enormous amount of weight on it. . . . [T]here were additional risk factors in the D&X group for subsequent premature delivery. . . . [F]ormally as a clinician-researcher, I wouldn't draw any conclusions from it.

Neb. Tr. 1721:23-1722:4; *see also* Cal. Tr. 971:10-971:13 (testimony of government's expert witness, Dr. Watson A. Bowes, Jr., that the Chasen study "certainly does not suggest that D&E where the fetus is removed intact is any less safe than where the [fetus] is disarticulated").

The conclusions of Dr. Chasen and Dr. Lockwood that the data do not indicate an increased risk of subsequent preterm birth in the intact D&X group are based on an accurate understanding of p-value and are consistent with accepted methods of statistical analysis. These conclusions were also endorsed by the district courts in Nebraska and California. *See Carhart v. Ashcroft*, 331 F. Supp. 2d 805, 1022-23 & n.150 (D. Neb. 2004) (crediting the testimony of Dr. Lockwood over that of Dr. Clark about the risk of subsequent preterm birth); *Planned Parenthood Fed'n of Am. v. Ashcroft*, 320 F. Supp. 2d 957, 1001 (N.D. Cal. 2004) (finding that the Chasen study does not support a conclusion that intact D&X may lead to an increased risk of subsequent preterm birth).

Amici urge this Court to disregard the testimony of Dr. Clark about the relative risk of preterm birth in subsequent pregnancies for intact D&X and D&E, and similarly to reject any arguments by the Solicitor General or supporting *amici* based on that testimony.

C. Dr. Clark's Statements About The Meaning Of A P-value Of 0.30 Are Incorrect And Should Be Disregarded.

In addition to drawing a statistically invalid conclusion about the Chasen study data, Dr. Clark made two inaccurate statements about the meaning of p-value in his testimony that are not in accord with accepted principles in the scientific community.

First, Dr. Clark implied that p-values of 0.30 and 0.05 were substantively similar. In his testimony about the difference in the incidence of spontaneous preterm birth in the two patient groups, Dr. Clark conceded that the result

would be statistically significant only if the p-value were less than 0.05, but then erroneously suggested that the 0.30 p-value in the Chasen study was roughly equivalent to a p-value of 0.05:

> Well, I would say that if the P value is less than .05 then there is absolutely no question. Usually we don't accept something as absolute scientific truth unless the chances are less than five percent. ***In this particular case it's just stretching it a little bit to say 30 percent chance***, but you're roughly correct.

N.Y. Tr. 2426:2-2426:8 (emphasis added). Contrary to Dr. Clark's statement, a p-value of 0.30 does not even approach the level of statistical significance indicated by a p-value of 0.05. A p-value of 0.30 means that, if intact D&X and D&E truly posed the same risk of subsequent preterm birth and we conducted the Chasen study multiple times, we would expect to observe the same (or greater) difference in subsequent preterm births that we observed in the Chasen study 30% of the time. Given that we would observe the same (or greater) difference relatively frequently—almost one third of the time—it would be inappropriate to reject our null hypothesis that intact D&X and D&E are similar. Only when the likelihood of observing that difference is small—5% percent or less—can we validly conclude that the difference we observed is significant. Dr. Clark's assertion that a p-value of 0.30 can be "stretched" to equate to a p-value of 0.05 is simply incorrect.

Second, Dr. Clark erroneously testified that 1 minus 0.30, or 0.70 (70%), could measure whether there was an actual difference between intact D&X and D&E in the risk of subsequent preterm birth:

> [T]here is a 30 percent chance this occurred by chance and a 70 percent chance that it in fact is a true, meaningful, increased risk . . . .

N.Y. Tr. 2429:20-2429:22; *see also id.* at 2426:12-2426:13 ("[T]here is a 70 percent chance that in fact this is a real difference."). This misstatement was subsequently adopted in the district court's opinion in *NAF*. *See NAF*, 330 F. Supp. 2d at 476-77.

Dr. Clark's statements fundamentally misconstrue the meaning of p-value. A p-value is not the probability that there is no real difference between two groups, and one minus a p-value is not the probability that there is an actual difference between two groups. P-values are calculated ***assuming that there is no real difference between the two groups***. A p-value can only tell us the likelihood that an observed difference between two groups would be repeated in subsequent studies, assuming the null hypothesis were true. To use the Chasen study as an example, a p-value of 0.30 means that, if the Chasen study were rerun multiple times, and there were in fact no true difference in subsequent obstetric outcomes between intact D&X and D&E, then one would expect to see differences as large or larger than the one observed in the Chasen study in 30% of the subsequent trials and differences smaller than the one observed in the Chasen study in 70% of the subsequent trials. N.Y. Tr. 2683:5-2683:19 (Howell). The 0.30 p-value does not measure the percentage likelihood that there is a "real difference" between intact D&X and D&E that caused the difference in subsequent preterm birth rates.

Dr. Clark's testimony that the Chasen study indicates a 70% chance of increased risk of subsequent premature birth

following intact D&X is therefore incorrect and should be rejected.

D. Dr. Chasen's Follow-up Study Suggests That The Risk Of Subsequent Preterm Birth Was Correlated To The Patient's Medical Indication For Abortion, Not To The Procedure She Received.

Dr. Chasen's follow-up study, published in 2005 in the *American Journal of Obstetrics and Gynecology*, provides further evidence that the higher percentage of subsequent preterm births observed in the intact D&X group was not caused by any heightened risk of the procedure itself, but instead was related to the medical condition of the woman seeking the initial abortion. Stephen T. Chasen *et al.*, *Obstetric outcomes after surgical abortion at ≥ 20 weeks' gestation*, 193 Am. J. Obstet. Gynecol. 1161 (2005) (the "Chasen follow-up study") (attached as Appendix B).

The Chasen follow-up study examined data from the same patient sample of 383 women in the original Chasen study, but had a different objective. The Chasen follow-up study sought to "identify risk factors for spontaneous preterm birth" and, as a secondary goal, to assess whether intact D&X or D&E was "associated with higher rates of spontaneous preterm birth in future pregnancies." *Id.* at 1162. With over a year of additional follow-up data available since the publication of the original study, the number of subsequent pregnancies among the 383 women increased from 62 to 120.[4] Of these 120 subsequent pregnancies, 102 reached the

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[4] *Amici* in support of Petitioner imply that the addition of 58 pregnancies from the time of the original Chasen study to the time

third trimester and could be evaluated for subsequent preterm birth rates. Within that sample, spontaneous preterm births occurred in only 7 of the pregnancies, 3 in the intact D&X group and 4 in the D&E group.

The Chasen follow-up study identified two factors that appeared to contribute to the risk of subsequent preterm birth in the study population, neither of which related to the abortion procedure the woman had previously undergone: (1) whether the patient had received an abortion due to preterm premature rupture of membranes (PPROM) or spontaneous cervical dilation, medical conditions already known to carry a heightened risk for spontaneous preterm birth in subsequent pregnancies, and (2) whether the patient's subsequent pregnancy involved multiple fetuses, such as twins or triplets, which typically deliver prematurely. *Id.* at 1162-63.

Dr. Chasen found that 27.3% (3 out of 11) of the women in the study population who underwent abortion due to PPROM or spontaneous cervical dilation experienced subsequent preterm births, compared to 4.4% (4 out of 91) of

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of the follow-up study is suspect. *See* Br. of *Amici Curiae* AAPLOG *et al.* 25 n.91 (the Chasen follow-up study used the dataset from the original study, "but somehow [found] twice as many prenatal patients"). This contention has no basis. The original Chasen study contained data on 62 subsequent pregnancies in 62 women; in other words, one subsequent pregnancy per woman. The follow-up study, on the other hand, contained data from 120 pregnancies in 89 women; in other words, it included women who had multiple subsequent pregnancies. Hence, while the number of *subsequent pregnancies* in the sample nearly doubled, the number of *prenatal patients* did not.

the women who underwent abortion for other reasons. That difference was statistically significant with a p-value of 0.03. Dr. Chasen also found that women who received an abortion due to PPROM or spontaneous cervical dilation made up a significantly greater percentage of the patients who had received intact D&X compared to those who received D&E (25% versus 4.3%, p-value = .001), and that the rates of subsequent preterm birth among patients who had undergone the earlier abortion for other medical reasons "were nearly identical" among those who had undergone intact D&X and those who had undergone D&E (4.2% versus 4.5%). *Id.* at 1163.

From these data, Dr. Chasen concluded that "[t]he association between surgical abortion and subsequent spontaneous preterm birth in these women is related to the indication for abortion, rather than the abortion procedure itself" and that "[s]urgical abortion with either variation of D&E late in the second trimester should not be considered a risk factor for subsequent spontaneous preterm birth." *Id.* Although Dr. Chasen conceded that the sample size of his follow-up study was too small to rule out the possibility that either intact D&X or D&E may increase the risk of subsequent preterm birth, the study provides concrete data supporting an alternative explanation for the numerical difference in the incidence of preterm birth between the intact D&X and D&E groups.

Amici believe the results of the follow-up study support Dr. Chasen's explanation for the difference in preterm birth rates observed between the intact D&X and D&E groups. The follow-up study's statistical evidence is certainly more scientifically compelling than the speculative assertion offered by Dr. Clark in his testimony that the numerical

difference may have resulted from the greater cervical dilation that occurs with intact D&X. N.Y. Tr. 2386:12. The district court in *Carhart*, which considered both explanations in connection with the original Chasen study, concurred. *See Carhart*, 331 F. Supp. 2d at 963-64, 1022-23; *see also* Cal. Tr. 971:10-971:13 (Bowes) (agreeing that the Chasen study does not suggest that intact D&X is "any less safe" than D&E).

Accordingly, this Court should not credit Dr. Clark's speculative causation hypothesis or the arguments based on that speculation put forth by the Solicitor General and supporting *amici*. *See* Petr.'s Br. (*Carhart*) 37-38 n.12; Br. of *Amici Curiae* AAPLOG *et al.* 19-20.

II. Testimony That The Chasen Study Data Showed "Trends" Toward Increased Risk In The Intact D&X Group Is Unfounded And Contradicted By Additional Data From Dr. Chasen's Follow-Up Study.

Unlike Dr. Clark, the government's other expert witnesses did not assert that the numerical increase in the incidence of subsequent preterm birth in the intact D&X group suggested an actual difference between intact D&X and D&E. Instead, Dr. M. LeRoy Sprang and other government experts made a similarly invalid claim by testifying that the numerical increase, while not statistically significant, represented a "trend" that was cause for concern. Neb. Tr. 1158:8-1159:10 (Sprang); N.Y. Tr. 2122:8-2122:21 (Sprang); Cal. Tr. 1106:9-1107:15 (Sprang); N.Y. Tr. 2547:4-2547:8 (Cook). Dr. Sprang also mistakenly identified another purported "trend" in the data on cervical lacerations and all genital tract lacerations, which showed a roughly threefold and twofold numerical increase, respectively, in the

intact D&X group. Neb. Tr. 1159:15-1160:2; N.Y. Tr. 2122:22-2123:16, 2124:22-2125:8; Cal. Tr. 1103:21-1104:6. According to Dr. Sprang, both of these "trends" "would support that D&X has more risk than D&E." Neb. Tr. 1160:8-1160:11.

Dr. Sprang's assertions, like those of Dr. Clark, are not grounded in accepted principles of statistical analysis and should be disregarded, as should the portions of Judge Straub's dissent in *NAF* and the government's supporting *amicus* briefs that credit Dr. Sprang's testimony. *See Nat'l Abortion Fed'n v. Gonzales*, 437 F.3d 278, 309 (2d Cir. 2006) (Straub, J., dissenting); Br. of *Amici Curiae* Congressman Ron Paul *et al.* 9-10; Br. of *Amici Curiae* AAPLOG *et al.* 20 n.73.

A. The P-values In The Chasen Study Do Not Indicate Even Borderline Statistical Significance.

As explained above, statisticians require a p-value of 0.05 or less before concluding that an observed difference is statistically significant. As p-value gets closer to 0.05, it becomes more difficult to attribute the observed difference to chance. Where the p-value falls just shy of that mark, statisticians may assign a borderline or marginal significance to the observed difference. Generally, only a p-value falling between 0.05 and 0.10 qualifies as marginally significant. Thus, if the p-value approaches 0.05, but does not meet or fall below that threshold, statisticians will not reject the null hypothesis by concluding that the observed difference is statistically significant, but they might determine that the null hypothesis should be tested further. Outside this p-value range, there is still enough likelihood that the difference was caused by chance that it would be invalid to conclude that the

observed difference is even marginally significant, or, to use Dr. Sprang's terminology, that there is a "trend."[5]

In the Chasen study, the observed difference in the incidence of spontaneous preterm birth between the intact D&X and D&E groups was 11.8% versus 4.4%, with a p-value of 0.30. That measure falls well outside the range of marginal significance. Dr. Chasen did not calculate p-values for the operative and post-operative complications he measured, which included cervical lacerations and all genital tract lacerations (cervical, perineal, and labial), but he did report the number of those complications that occurred in each treatment group. Dr. Chasen found that 3 patients in the intact D&X group and 2 patients in the D&E group, or 2.5% versus 0.8%, experienced cervical lacerations during the procedure. Similarly, 4 patients in both the intact D&X and D&E groups, or 3.3% versus 1.5%, experienced genital tract lacerations. Chasen, *Dilation and evacuation, supra,* at 1182. The p-values for these differences are 0.18 and 0.26, respectively. Both fall well outside the 0.05 to 0.10 range and therefore do not support a finding of even marginal statistical significance.

Dr. Sprang's own testimony identified the very reason why it is inappropriate to draw any conclusions from these

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[5] As a technical matter, the use of the term "trend" in this context is inappropriate. The statistical term "trend" generally refers to changes that occur over time; for example, an increase in the unemployment rate each year for 10 years accurately can be termed a trend. In contrast, the Chasen study contains no indication that the rate of complications from D&E or intact D&X increases or decreases over time. A true test of trend in results requires a different statistical test than was performed in this study.

numbers: "[W]hen you look at [the data] because the numbers were so small it's hard to draw meaningful conclusions." N.Y. Tr. 2121:16-2121:17. It is precisely because so few of these events occurred in the study, a factor that the p-value calculations of 0.30, 0.18 and 0.26 take into account, that it is invalid to conclude that these differences are statistically significant or even marginally significant. That is, there are not enough data in the study on spontaneous preterm births, cervical lacerations, or genital tract lacerations to conclude for any of these events that a "trend" exists in the intact D&X group. Indeed, the government's own experts could not agree on which of these differences indicated a "trend" and which did not. *Compare* Neb. Tr. 1158:8-1160:11; N.Y. Tr. 2122:8-2125:8 (Sprang) (finding "trends" in all three events), *with* N.Y. Tr. 2419:15-2419:24, 2416:4-2416:13 (Clark) (stating that intact D&X posed "significant hazards to future pregnancies," but that intact D&X and D&E showed "no difference in any short-term outcome"), *and* Neb. Tr. 1719:16-1722:8 (Lockwood) (testifying that he "wouldn't draw any conclusions" from the difference in spontaneous preterm births and that "it would be extraordinarily unlikely that these two procedures have markedly different occurrences in the rate of . . . short-term complications.").[6]

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[6] Furthermore, all three of the serious complications in the Chasen study that required admission of the patient to the surgical intensive care unit—one amniotic fluid embolus, one pulmonary embolus, and one uterine perforation—occurred in the D&E group. *See* Chasen, *Dilation and evacuation, supra*, at 1182. By Dr. Sprang's logic, these data would indicate a "trend" against D&E for all serious complications, despite the obvious paucity of data.

Amici do not mean to imply that there would be no benefit in further examining the complications or subsequent obstetric outcomes of intact D&X and D&E. The data from the Chasen study taken alone, however, simply do not suggest—even marginally—that there is an increased risk of operative or post-operative complications, or subsequent preterm birth, among women who receive intact D&X, compared to those who receive D&E. *Amici* therefore urge this Court to disregard the unfounded testimony of Dr. Sprang and others on the statistical meaning of the Chasen study data.

B. The Numerical Difference In The Incidence Of Subsequent Preterm Birth Between The Intact D&X And D&E Groups Decreased In Dr. Chasen's Follow-up Study.

Dr. Chasen's follow-up study offers additional evidence that the numerical differences observed in the original Chasen study are not indicative of true differences in the subsequent obstetric outcomes of intact D&X and D&E, but are simply the consequence of small numbers. As noted above, the follow-up study reported data from an additional 58 subsequent pregnancies from within the original study population of 383 women. Chasen, *Obstetric outcomes, supra*, at 1162. These additional data nearly doubled the number of subsequent pregnancies that could be used to measure the incidence of spontaneous preterm birth, up from 62 in the original Chasen study to 120 in the follow-up study. Dr. Chasen found that, with the increased sample size, the difference in the rate of subsequent preterm births between the intact D&X and D&E groups narrowed considerably from 11.8% (2 out of 17) versus 4.4% (2 out of 45) in the original study to 9.4% (3 out of 32) versus 5.7% (4 out of 70)

in the follow-up study, down from a roughly threefold numerical difference to a difference of just over one and one half. *Id.* at 1163. Similarly, the p-value for this difference more than doubled from 0.30 in the original study to 0.68 in the follow-up study, departing even further from the 0.05 threshold for statistical significance. *Id.*

The Chasen follow-up study illustrates perfectly why it is invalid to conclude that there is an actual difference between two outcomes when the p-value does not equal or fall below 0.05. The data from the follow-up study suggests that the difference in spontaneous preterm births observed in the original Chasen study was the result of chance fluctuations due to small numbers. Adding more subsequent pregnancies to the sample, similar to adding more coin flips to our example, caused the observed difference to decrease, the p-value to increase, and the so-called "trend" to evaporate. As a result of the Chasen follow-up study, there is now even less reason to credit the claims of Dr. Sprang.[7]

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[7] *Amici* disagree with the brief of the AAPLOG *amici*, which argues that "because the D&X data were excluded when D&X was performed in the presence of [PPROM] and/or advanced cervical dilation," no valid conclusions about preterm birth can be drawn from the Chasen follow-up study. Br. of *Amici Curiae* AAPLOG *et al.* 25 n.91. The 9.4% and 5.7% figures reported in the study represent the rates of *all* preterm births in intact D&X and D&E groups, respectively, *including* patients in those groups who received an abortion due to PPROM and/or advanced cervical dilation.

III. Courts Require A P-value Of 0.05 Or Less, Or Its Statistical Equivalent, Before Concluding That An Observed Difference Is Statistically Significant.

Courts analyzing statistical evidence have widely adopted the principle that a p-value of 0.05 or less, or a roughly equivalent measure of at least 2–3 standard deviations between an expected outcome and an observed outcome, is the appropriate gauge for determining whether observed differences among groups are statistically significant, as opposed to the result of mere chance. Accordingly, courts have required a p-value calculation of 0.05 or less, or a minimum of 2–3 standard deviations, before crediting a claim of actual difference between two groups.[8]

For example, in analyzing claims of racial discrimination in the grand jury selection process in *Castaneda v. Partida*, 430 U.S. 482 (1977), this Court relied upon the principle that statistical significance is achieved where a difference of greater than two or three standard deviations is observed between the expected outcome and the

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[8] Standard deviations can be used to measure the degree to which an observed result differs from the expected result, assuming the null hypothesis were true. Generally speaking, a p-value of 0.05 is equivalent to 1.96 standard deviations. For simplicity's sake, it is commonly said that a p-value of 0.05 is analogous to 2 standard deviations and a p-value of 0.01 is analogous to 3 standard deviations. As such, an observed outcome of greater than two or three standard deviations from the expected outcome is generally required for a finding of statistical significance.

observed outcome. *See id.* at 497 n.17.[9] In *Castaneda*, a difference of twelve standard deviations between the racial composition of a randomly selected grand jury pool and the pool at issue was held sufficient to establish the defendant's *prima facie* case of discrimination. *See id.* at 496; *see also Hazelwood Sch. Dist. v. United States*, 433 U.S. 299, 309 n.14, 311 n.17 (1977) (analyzing racial composition of workforce and repeating *Castaneda* principle that a difference of greater than 2–3 standard deviations would cast doubt on hypothesis that workforce was hired randomly without regard to race).

The courts of appeal take a similar approach in analyzing the meaning of statistical evidence in a variety of contexts. *See, e.g., Smith v. Xerox Corp.*, 196 F.3d 358, 366-67 (2d Cir. 1999) (requiring p-value of 0.05 or less, equivalent to 2 standard deviations, to establish statistical significance of data supporting disparate impact claims); *Benson v. Tocco, Inc.*, 113 F.3d 1203, 1209 (11th Cir. 1997) (observing that standard deviation of 3.04 between rate of termination for employees under age 40 and those over age 40, and standard deviation of 2.66 between rate of

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[9] *Amici* note that whereas the *Castaneda* court discussed the significance of the 2–3 standard deviation threshold in the context of a binomial distribution of data, the Chasen data are based on hypergeometric distributions. Although equating standard deviations to p-values for data based on hypergeometric distributions is more complicated than for a binomial or a normal distribution, particularly when the sample size is relatively small, the principle that an outcome of 2–3 standard deviations is roughly equivalent to a p-value of 0.05 or less remains the same, subject to minor fluctuations depending on the distribution and symmetry of the data.

termination for employees under age 50 and those over age 50, would support an inference of discriminatory termination); *Ford v. Seabold*, 841 F.2d 677, 688-89 & n.12 (6th Cir. 1988) (rejecting statistical evidence relating to composition of grand jury pool because "probability [that number of nonwhites in jury pools would deviate from the population] did not reach the 0.05 level, the level which most statisticians . . . deem statistically significant" and observing that "[t]he two or three standard deviation benchmark applied in *Castaneda* is essentially equivalent to probability values of 0.05 and 0.01 respectively"); *Eldredge v. Carpenters 46 N. Cal. Counties Joint Apprenticeship & Training Comm.*, 833 F.2d 1334, 1340 n.8 (9th Cir. 1987) (holding that level of significance of 0.045 in percentage difference of men and women admitted to apprenticeship program gave rise to inference of discrimination); *Segar v. Smith*, 738 F.2d 1249, 1282-83 (D.C. Cir. 1984) (observing that "social scientists usually accept a study that achieves statistical significance at the .05 level").

Accordingly, this Court should not hesitate to conclude that the p-value calculations from both Chasen studies of 0.68, 0.30, 0.26, and 0.18—all well above the 0.05 threshold—fail to demonstrate a statistically significant, or even a marginally significant, difference in the rate of spontaneous preterm births or cervical/genital tract lacerations between the intact D&X and D&E groups. Any suggestion that the numerical differences between the two groups signifies something more meaningful than mere chance finds no support in fundamental principles of statistical analysis, and is at odds with courts' established method of interpreting statistical evidence.

CONCLUSION

The Chasen study and its follow-up are critical pieces of scientific evidence concerning the safety of intact D&X. If the Court chooses to consider the Chasen data in its constitutional analysis of the Partial-Birth Abortion Ban Act of 2003, *amici* believe those data should be evaluated objectively and in accordance with widely accepted principles of statistical analysis. Straightforward p-value calculations indicate that there is no evidence in the Chasen data upon which to base a conclusion that intact D&X is more dangerous than D&E. The Court should not be misguided by the unfounded and speculative assertions to the contrary of Dr. Clark, Dr. Sprang, and other government experts. For the foregoing reasons, *amici* urge this Court to disregard those misstatements, along with the arguments of Petitioner and supporting *amici* that perpetuate them, and instead to evaluate the results of the Chasen data using principles of interpretation that form the standard relied upon by the scientific community.

Respectfully submitted.

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APPENDIX A

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EDITORS' CHOICE

Dilation and evacuation at ≥20 weeks: Comparison of operative techniques

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KEY WORDS

Abortion
Dilation and evacuation

Objective: The objective of this study is to compare the relative safety of 2 techniques for surgical abortion late in the second trimester.

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Study design: Retrospective review of patients who underwent surgical abortion at ≥20 weeks' gestation at our hospital from June 1996 through June 2003. Records were reviewed to determine whether the technique used was dilation and evacuation or intact dilation and extraction. Subsequent pregnancies at our hospital were identified, and obstetric outcomes were recorded. Categorical data were compared with Fisher exact test and χ^2 analysis. Continuous data were compared with Mann-Whitney *U* test.

Results: Three hundred eighty-three patients met inclusion criteria. Intact dilation and extraction was performed in 120 cases, and dilation and evacuation was used in 263. Intact dilation and extraction was associated with higher parity, later gestational age, and more preoperative cervical dilation. There was no difference in procedure time or estimated blood loss in the 2 groups. Complications occurred in 19 cases (5.0%), and occurred with similar frequency in the 2 groups. We identified 62 subsequent pregnancies. There were no second-trimester miscarriages. Spontaneous preterm birth occurred in 2 of 17 (11.8%) pregnancies in the intact dilation and extraction group, compared with 2 of 45 (4.4%) in the dilation and evacuation group ($P = .30$).

Conclusion: Outcomes appear similar between patients undergoing dilation and evacuation and intact dilation and extraction after 20 weeks' gestation. Subsequent obstetric outcomes are similar between the 2 groups. The technique for surgical abortion should be determined by the physician on the basis of intraoperative factors.

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In the United States, induced abortion late in the second trimester is uncommon. In 1999, 9643 abortions

were performed at ≥21 weeks' gestation, representing only 1.5% of total abortions reported.[1] Dilation and evacuation is the most common method used for second trimester abortion[1] and is considered the safest abortion technique in the second trimester.[2-5]

Dilation and evacuation involves preoperative dilation of the cervix with osmotic dilators, such as laminaria, which are placed in the cervix for 1 or more days before operative evacuation. All published reports of dilation and evacuation have described the use of grasping forceps to remove the fetus and placenta. With the use of forceps, fetal parts are grasped, and the fetus and placenta are disarticulated as they are removed. Low complication rates for this procedure have been reported.[2-5]

A variant of dilation and evacuation can be performed when sufficient cervical dilation is present. In these cases, the fetus is delivered via breech extraction. If the fetus is not in the breech presentation, internal podalic version may be performed. In most cases, after delivery of the body, the fetal head will become lodged in the cervix, and cranial decompression with suction must be performed to complete delivery. This procedure has been referred to as intact dilation and extraction, or D&X. There are no published data regarding the frequency or complication rate of this procedure. Despite this, some have stated that this procedure poses serious maternal risks and is less safe than dilation and evacuation.[6,7]

The objective of this study is to evaluate the relative safety of dilation and evacuation and intact D&X in patients undergoing surgical abortion late in the second trimester.

Materials and methods

This study was a review of patients who underwent surgical abortion at ≥20 weeks' gestation at the New York

Weill Cornell Medical Center from June 1996 to June 2003. All procedures included in this study were performed by 1 of 2 physicians (S.T.C. and W.K.R) who are skilled in both techniques, dilation and evacuation and intact D&X. Institutional Review Board approval was obtained for this study.

Gestational age was confirmed by ultrasound in all cases. All cases ≥24 weeks' gestation were performed because of fetal demise. Dilation of the cervix was achieved with insertion of laminaria. Laminaria were placed preoperatively on 2 consecutive days, unless the cervix was sufficiently dilated at the initial examination. Women who went into labor after laminaria placement and delivered without dilation and evacuation or intact D&X were not included in this study.

The surgical technique was determined when the patient was examined under anesthesia, and was based on cervical dilation and fetal position. Both physicians performing these procedures used similar criteria in determining the optimal surgical technique. All cases were considered complete when, after evacuation of the fetus and placenta, hemostasis was apparent after sharp and suction curettage. Blood loss was estimated by the surgeon. Procedures were performed in an ambulatory setting, unless patients had been hospitalized before the procedure for medical or obstetric conditions. The type of anesthesia used for the procedure, general, regional, or intravenous sedation, was at the discretion of the anesthesiologist. Intraoperative ultrasound guidance was not routinely used.

Operative reports were reviewed to determine the technique used in each case. If the fetus was delivered intact in the breech presentation to the level of the umbilicus or higher, the procedure was considered an intact D&X, whether the entire fetus was removed intact

or decompression of the head was required. In some cases, the presenting fetal head was well applied to the cervix and was initially decompressed with suction, followed by intact delivery of the fetus. These cases were also considered intact D&Xs, as disarticulation with forceps was not required. All other cases, which were performed with multiple insertions of forceps, were categorized as dilation and evacuation.

Complications included any situation requiring unplanned intervention. These included unplanned hospital admission, repair of any genital tract lacerations, return to the operating room for additional procedures, and blood transfusion. Subsequent pregnancies at our hospital were identified from a review of the medical records. We did not obtain follow-up on patients routinely, so subsequent pregnancies with prenatal care obtained elsewhere were not included in this analysis. Thirty-eight patients in this series, 26 of whom underwent dilation and evacuation and 12 of whom underwent intact D&X, were included in a prior publication describing obstetric outcome after second trimester abortion.[8]

Demographic characteristics and outcomes were compared on basis of operative technique. Categorical variables were analyzed with the use of 2-tailed Fisher exact test and χ^2 analysis where appropriate. Mann-Whitney *U* test was used to analyze continuous variables, which were not normally distributed. Analysis was performed with SPSS 11.0 (Chicago, Ill). A *P* value <.05 was considered significant.

Results

Three hundred eighty-three patients met inclusion criteria. Intact D&X was performed in 120 cases (31.3%), and dilation and evacuation was used in 263 (68.7%).

Demographic characteristics of the 2 groups are listed in Table I. Intact D&X was associated with later gestational age, higher parity, and younger maternal age.

Indications for surgical abortion are listed in Table II. Preterm cervical dilation and/or preterm premature rupture of membranes (PPROM) were more common in those who underwent intact D&X. Abnormal fetal karyotype was more common in those who underwent dilation and evacuation.

Intraoperative variables are listed in Table III. Overall, laminaria were used in 96.1% of cases. Laminaria were less likely to be used in patients undergoing intact D&X. All 15 patients in whom laminaria were not used had preterm cervical dilation. Preoperative cervical dilation was greater in those who underwent intact D&X.

Table I Demographic characteristics of patients undergoing dilation and evacuation

	D & E (n = 263)	D & X (n = 120)	*P* value
Median maternal age (range)	34 y (16-45)	32 y (12-43)	.01*
Median parity (range)	0 (0-7)	1 (0-5)	.04*
Median gestational age at D & E (range)	21 wks (20-27)	23 wks (20-25)	<.001*
Prior vaginal delivery	81 (30.8%)	50 (41.7%)	.05†
Prior cesarean delivery	49 (18.6%)	26 (21.7%)	.49†
Multifetal pregnancy	13 (4.9%)	8 (6.7%)	.48†

D & E, Dilation and evacuation.

* Mann Whitney *U* test;

† Fisher exact test.

Table II Indication for dilation and evacuation*

Indication for D & E	D & E (n = 263)	D & X (n = 120)	*P* value†
Abnormal fetal karyotype	112 (42.6%)	33 (27.5%)	.005
Structural fetal abnormality	96 (36.5%)	47 (39.2%)	.65
Intrauterine fetal demise	27 (10.3%)	14 (11.7%)	.72
Premature cervical dilation/PPROM	14 (5.3%)	20 (16.7%)	.001
Other	22 (8.4%)	13 (10.8%)	.45

* Some patients had more than 1 indication;

† Fisher exact test.

No differences were noted in procedure time or estimated blood loss between the 2 groups.

In the entire group of 383 patients, complications occurred in 19 cases (5.0%). Complications occurred with similar frequency in the dilation and evacuation and intact D&X groups (4.9% vs 5.0%; $P > .999$). The 6 complications occurring in the intact D&X group included 4 genital tract lacerations (3 cervical mucosal lacerations and 1 perineal laceration) noted and successfully repaired at the time of surgery; 1 case of excessive bleeding requiring the return to the operating room on the day of surgery for curettage; and 1 patient readmitted because of heavy bleeding on postoperative day 13 who underwent curettage for retained placenta.

Complications in patients undergoing dilation and evacuation included 4 genital tract lacerations (2 cervical lacerations and 2 labial lacerations) noted and successfully repaired at the time of surgery; 2 cases of

excessive bleeding requiring the return to the operating room on the day of surgery (for curettage in 1 case, and repair of cervical lacerations in 1 case); 2 postoperative admissions for intravenous antibiotics because of endometritis; 1 admission for observation after excessive bleeding; and 1 admission because of severe nausea from general anesthesia.

Table III Intraoperative variables

	D & E (n = 263)	D & X (n = 120)	*P* value
Laminaria	259 (98.5%)	109 (90.8%)	.001*
Median preoperative cervical dilation (range)	3 cm (0-6)	5 cm (2-10)	.001†
Anesthesia			
General	92 (35.05%)	53 (44.2%)	.22‡
Regional	9 (3.4%)	3 (2.5%)	
Local/conscious sedation	162 (61.6%)	64 (53.3%)	
Median procedure time (range)	22 min (6-60)	22 min (6-45)	.54†
Median estimated blood loss (range)	100 mL (40-1500)	100 mL (20-1200)	.38†

* Fisher exact test;
† Mann-Whitney *U* test;
‡ Chi-square analysis.

Three patients, all of whom underwent dilation and evacuation, had complications requiring admission to the surgical intensive care unit. One patient, with a fetal

demise, had an amniotic fluid embolus with disseminated intravascular coagulation requiring transfusion of blood and clotting factors. One patient was diagnosed with sepsis and pulmonary embolus. One patient had a uterine perforation at the site of a cesarean delivery scar and required exploratory laparotomy and blood transfusion.

Forty-five women (17.1%) in the dilation and evacuation group and 17 women (15.0%) in the intact D&X group had a subsequent pregnancy and received care at our medical center. There were no second-trimester spontaneous abortions in either group. Spontaneous preterm birth occurred in 2 of 17 (11.8%) pregnancies in the intact D&X group compared with 2 of 45 (4.4%) in the dilation and evacuation group ($P = .30$). Both spontaneous preterm births in the intact D&X group occurred in women at high risk for prematurity: one woman, who underwent intact D&X caused by PPROM at 23 weeks' gestation, subsequently delivered at 32 weeks, and the other underwent intact D&X at 23 weeks' gestation because of cervical incompetence with advanced cervical dilation, and subsequently delivered at 35 weeks.

Comment

On the basis of this series of 383 patients, surgical abortion late in the second trimester is a safe procedure. There were low rates of complications in procedures performed with either technique. As described in a prior publication,[8] we did not see a high rate of spontaneous preterm birth in subsequent pregnancies in those who received obstetric care at our medical center.

Because this study was retrospective, we cannot state that one technique is superior to the other. Procedures performed with intact D&X occurred at later gestational ages and with more preoperative cervical dilation.

Although more advanced gestation might be expected to increase complication rates, more preoperative cervical dilation might be expected to facilitate these procedures.

Differences between maternal age, gestational age, and indication for surgical abortion were noted between the 2 groups. The difference in gestational age may be due to changes in the cervix that occur as pregnancy progresses. With advancing gestation, the cervix may be more likely to respond to laminaria placement with greater dilation. Intact D&X requires more dilation, as the intact fetus cannot pass through a minimally dilated cervix. In addition, more women in the intact D&X group underwent abortion caused by premature cervical dilation or PPROM. The incidence of these conditions increases with advancing gestation, and the spontaneous cervical dilation occurring in these cases probably facilitated intact D&X.

The difference in maternal age is likely because of the higher rate of fetal aneuploidy in the dilation and evacuation group. Amniocentesis is typically performed at 16 to 18 weeks, and advanced maternal age is the most common indication. Most cases of fetal aneuploidy are identified by 20 weeks. This could explain why those in the dilation and evacuation group were older, and underwent abortion at earlier gestational ages.

Our approach of performing intact D&X when possible is intended to minimize the use of forceps in extracting the fetus. We believe that the use of forceps to grasp the fetus can cause inadvertent trauma to the uterine wall. At these gestational ages, evacuation of a fetus can require multiple insertions of forceps, and intact D&X avoids this. Though we believe our low complication rate validates our approach, we acknowledge that the retrospective nature of this study precludes us from

concluding with certainty that intact D&X prevented adverse outcomes.

Another important limitation is the relatively small number of patients receiving prenatal care at our hospital in subsequent pregnancies. Most patients returned to their referring obstetrician for future obstetric care, and we were unable to assess subsequent pregnancy outcomes of patients delivered at other institutions. We believe that significant bias as a result would be unlikely, though we cannot be certain that outcomes in pregnancies followed at our hospital are representative of outcomes in all subsequent pregnancies. Though we are reassured by the low number of complications in subsequent pregnancies in both groups, we acknowledge our lack of power to conclude that subsequent pregnancy outcomes are not different.

Some have stated that intact dilation and extraction poses serious risks to the health of a woman beyond the risks associated with dilation and evacuation. Such putative risks include higher rates of cervical incompetence, uterine rupture, abruption, amniotic fluid embolism, and trauma to the uterus.[6,7] We are not aware of any published data supporting these statements. In our patients, the overall rate of complications was comparable between those undergoing dilation and evacuation and intact D&X. No patient undergoing intact D&X experienced uterine rupture, amniotic fluid embolism, or required blood transfusion. Because our approach is to perform intact D&X when possible on the basis of cervical dilation and fetal position, it is unlikely that intact D&X could have been performed in these patients undergoing dilation and evacuation who experienced severe complications.

In conclusion, our data affirm that abortion after 20 weeks' gestation with intact D&X appears to have sim-

ilar complication rates as dilation and evacuation when performed by experienced physicians. The observed complication rates and subsequent obstetric outcomes appear comparable between the 2 techniques. In accordance with the American College of Obstetricians and Gynecologists statement of policy,[9] our data supports that the most appropriate technique for surgical evacuation of pregnancy after 20 weeks' gestation should be based on intraoperative factors. Attempts to regulate intact D&X on the basis of concern for maternal well-being cannot be supported by available evidence.

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APPENDIX B

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Obstetric outcomes after surgical abortion at ≥20 weeks' gestation

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Objective: The purpose of this study was to describe obstetric outcomes after surgical abortion at ≥20 weeks, and to identify risk factors for subsequent spontaneous preterm birth.

Study design: Patients who had surgical abortion at ≥20 weeks' gestation from 1996 to 2003 and received subsequent prenatal care at The New York Weill Cornell Medical Center were identified. Indication for abortion, operative technique, and subsequent pregnancy outcomes were reviewed. Student *t* test, Fisher exact test, and Mann-Whitney *U* were used where appropriate.

Results: One hundred and twenty pregnancies in 89 women were identified. Thirteen (10.8%) ended with early miscarriage, and 5 were electively terminated. Of the remaining 102 pregnancies, 7 ended with spontaneous preterm birth. Those who experienced preterm birth were more likely to have undergone abortion due to cervical dilation and/or preterm premature rupture of membranes (PPROM) (27.3% vs 4.4%; $P = .03$). Those with a multifetal pregnancy in the subsequent pregnancy were more likely to have preterm birth (75.0% vs 4.3%; $P < .001$). In patients who underwent dilation and evacuation (D&E) for reasons other than cervical dilation and/or PPROM, rates of spontaneous preterm birth were identical between those who had intact dilation and extraction (D&X) and D&E using forceps (4.2% vs 4.5%; $P = 1.0$).

Conclusion: In those who have undergone D&E at ≥20 weeks, only a history of midtrimester cervical dilation and/or PPROM or a current multifetal pregnancy were associated with spontaneous preterm birth.

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Dilation and evacuation (D&E) is considered the safest method of midtrimester abortion.[1,2] Although D&E has been categorized as a risk factor for future spontaneous preterm birth, published studies have not documented such an association.[3,4] Relatively few second trimester abortions are performed beyond 20 weeks' gestation; in the United States, only 1.4% of abortions were performed beyond 20 weeks in 2001.[5] Because these procedures typically require more cervical dilatation, it is plausible that D&E late in the second trimester could be a risk factor for future preterm birth.

Most D&Es involve disarticulation of the fetus with forceps. A variation of D&E, "intact dilation and extraction," or "intact D&X," has been described.[6] Intact D&X involves extraction of the largely intact fetus through the dilated cervix, and generally requires more cervical dilation. Complication rates for intact D&X are similar to those for D&E using forceps, although intact D&X is usually done later in pregnancy.[7] It has been suggested, in the absence of supportive data, that intact D&X in particular may increase the risk of subsequent preterm birth.[8,9]

Our objective was to describe the rate of and identify risk factors for spontaneous preterm birth in women who have undergone D&E at ≥20 weeks' gestation. A secondary objective was to determine whether operative technique is associated with higher rates of spontaneous preterm birth in future pregnancies.

Material and methods

Patients who underwent dilation and evacuation at our hospital at ≥20 weeks' gestation from 1996 to 2003, and who received subsequent prenatal care at The New York Weill Cornell Medical Center were identified by searching computerized hospital records using the appropriate

procedure codes. Gestational age had been confirmed by ultrasound in all cases. Medical records were reviewed to collect data about the terminated pregnancies, including the technique of surgical abortion, and the outcomes of subsequent pregnancies. This study was approved by the Institutional Review Board of our institution.

All patients underwent serial laminaria insertion before surgical abortion, unless spontaneous cervical dilation had already occurred. Laminaria were placed preoperatively on 2 consecutive days, and operative evacuation was performed on the third day. At each insertion, as many laminaria as could be accommodated by the cervix were placed. Patients received doxycycline the days of laminaria insertion and the day of operative evacuation for antibiotic prophylaxis. The operative technique was categorized as "D&E" if the procedure required disarticulation of the fetus with forceps. The operative technique was categorized as "intact D&X" if the fetus was delivered largely intact without disarticulation with forceps.[7] Spontaneous preterm birth was defined as delivery at <37 weeks' gestation resulting from preterm labor or preterm premature rupture of membranes (PPROM).

Fisher exact test was used to compare categorical outcomes. Student *t* test and Mann-Whitney *U* were used to compare continuous data. Statistical analysis was performed using Statistical Package for the Social Sciences (SPSS Release 11.0, SPSS, Inc, Chicago, Ill) software.

Results

There were 120 pregnancies in 89 women included in the study. These pregnancies were identified from a group of 383 patients who underwent surgical abortion at ≥20 weeks' gestation from 1996 to 2003. The outcomes of 62 of these pregnancies were briefly summarized in a pre-

vious publication that focused on operative techniques of surgical abortion late in the second trimester.[7]

The median maternal age at the time of surgical abortion was 33 years (interquartile range 29-37 years), and the median interval between abortion and the estimated date of confinement in a subsequent pregnancy was 18 months (interquartile range 14-33 months). The median gestational age at abortion was 21 weeks (interquartile range 20-23 weeks).

First trimester spontaneous abortion occurred in 13 (10.8%) pregnancies. Five pregnancies (4.2%) were electively terminated. There were no cases of second trimester pregnancy loss. The remaining 102 pregnancies occurred in 80 women. There were 93 deliveries at term. One woman with lupus nephritis underwent surgical abortion at 24 weeks' gestation because of fetal demise. Her 2 subsequent pregnancies were delivered at 31 weeks and 28 weeks because of HELLP syndrome. Spontaneous preterm birth occurred in the remaining 7 pregnancies (6.9%), which are described in Table I.

There were no significant differences in maternal age or gestational age at time of abortion with regard to the likelihood of subsequent spontaneous preterm birth. The association between indication for surgical abortion and subsequent spontaneous preterm birth can be seen in Table II. Of those undergoing abortion due to PPROM or spontaneous cervical dilation, 27.3% experienced spontaneous preterm birth in a subsequent pregnancy, compared with 4.4% of those undergoing abortion for other indications ($P = .03$; OR 8.2 [1.5-43.0]).

Those with a multifetal pregnancy after surgical abortion had a 75% incidence of spontaneous preterm birth, compared with 4.3% of those with a singleton pregnancy ($P < .001$; OR 70.5 [5.9-837.2]). In 87 singleton pregnancies in which surgical abortion was done for reasons

Table I Pregnancies with spontaneous preterm birth after surgical abortion at ≥20 weeks

Case	Indication for surgical abortion	Gestational age at abortion	Operative technique	Gestational age at next delivery	Number of fetuses
1	Aneuploidy	20 weeks	D&E	30 weeks	Singleton
2	Aneuploidy	21 weeks	D&E	31 weeks	Twin
3	PPROM	23 weeks	Intact D&X	32 weeks	Singleton
4	PPROM/IUFD	24 weeks	Intact D&X	35 weeks	Singleton
5	PPROM	21 weeks	D&E	36 weeks	Singleton
6	Aneuploidy	20 weeks	D&E	36 weeks	Twin
7	Aneuploidy	23 weeks	Intact D&X	36 weeks	Triplet

other than PPROM or cervical dilation, spontaneous preterm birth occurred in only 1 (1.1%).

The operative technique used was D&E in 70 cases and intact D&X in 32. There was no significant difference in the rate of spontaneous preterm birth between those who had undergone D&E versus intact D&X (5.7% vs. 9.4%; $P = .68$). PPROM and/or spontaneous cervical dilation were more common indications in those who had undergone intact D&X (25% vs 4.3%; $P = .001$). In the 91 patients who underwent abortion for other indications, the rates of subsequent spontaneous preterm birth were nearly identical between those who had undergone D&E and intact D&X (4.5% vs 4.2%; $P = 1.0$).

Comment

D&E is the most common procedure used to terminate a pregnancy in the second trimester in the United States. Lower complication rates have been described for D&E compared with medical induction.[1,2] D&E may also be preferable to some patients because it is typically done on an outpatient basis, and women do not have to endure labor. When Grimes et al attempted to perform a randomized clinical trial to compare D&E with medical induction using misoprostol and mifepristone, most women did not consent to randomization and opted to undergo D&E instead.[10] While most women may regard D&E as preferable to induction, many might reconsider if D&E were found to be a risk factor for subsequent preterm birth.

Based on our data, only those who have undergone surgical abortion late in the second trimester because of PPROM and/or premature cervical dilation are at high risk for spontaneous preterm birth in subsequent pregnancies. The high rate of subsequent spontaneous preterm birth seen in our patients with PPROM or cer-

vical dilation before surgical abortion (27.3%) is comparable to published data describing the rate of spontaneous preterm birth after midtrimester loss.[11] The association between surgical abortion and subsequent spontaneous preterm birth in these women is related to the indication for abortion, rather than the abortion procedure itself. The other significant association between multifetal pregnancy and preterm birth is obviously not surprising.

Table II Indication for abortion and subsequent spontaneous preterm birth

Indication for surgical abortion	No spontaneous preterm birth (n = 95)	Spontaneous preterm birth (n = 7)	*P* value
Fetal abnormality	69 (72.6%)	4 (57.1%)	0.40
Intrauterine fetal demise	12 (12.6%)	0 (0%)	1.0
PPROM or spontaneous cervical dilation	8 (8.4%)	3 (42.9%)	0.03
Other	6 (6.3%)	0 (0%)	1.0

Fisher exact test used for statistical comparison.

The rate of spontaneous preterm birth in singleton pregnancies after surgical abortion for indications other than PPROM and/or cervical dilation was only 1.1%. No patient who underwent surgical abortion using intact D&X for indications other than PPROM or cervical dilation delivered prematurely, with the exception of a triplet pregnancy delivered at 36 weeks. Our data do not support the notion that achieving advanced cervical dilation with laminaria is a risk factor for preterm birth. In fact, we have found that in women undergoing D&E

from 14 to 24 weeks, the risk of subsequent preterm birth was inversely correlated with the degree of cervical dilation achieved before surgical abortion.[3]

Because of the relatively small number of patients studied, we cannot exclude the possibility that surgical abortion late in the second trimester may increase the risk of spontaneous preterm birth. In our hospital, the rate of spontaneous preterm birth in singleton pregnancies is approximately 5%. To have an 80% likelihood of detecting a 50% increase in the rate of spontaneous preterm birth to 7.5% at a significance level of 0.05, we would need 539 patients. In this study with 102 pregnancies, our power to detect this magnitude of an increase in spontaneous preterm birth was only 34%.

In conclusion, surgical abortion at ≥20 weeks' gestation is not associated with a high risk for spontaneous preterm birth in future pregnancies. Surgical abortion with either variation of D&E late in the second trimester should not be considered a risk factor for subsequent spontaneous preterm birth.

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In the
Supreme Court of the United States

ALBERTO R. GONZALES, ATTORNEY GENERAL,
PETITIONER,

v.

LEROY CARHART, *ET AL.*,
RESPONDENTS.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

ALBERTO R. GONZALES, ATTORNEY GENERAL
PETITIONER,

v.

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., *ET AL.*,
RESPONDENTS

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF OF CONSTITUTIONAL LAW PROFESSORS, DAVID L. FAIGMAN AND ASHUTOSH A. BHAGWAT, *ET AL.*, AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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INTEREST OF THE *AMICI CURIAE*[1]

Amici are a group of law professors who teach and write in the area of constitutional law and who share a strong professional interest in issues relating to constitutional fact-finding and judicial review in constitutional cases. We seek to provide this Court with our professional academic perspective on these issues, as they arise in the cases at bar. Because our expertise does not extend to the substance of the underlying dispute – the medical value of a health exception to the Partial-Birth Abortion Ban Act of 2003 – we limit our analysis to the threshold question presented: What level of deference do courts owe Congress regarding congressional findings of fact that are relevant to determining whether federal legislation violates fundamental constitutional rights? We strongly believe that the position Petitioner advances here – that "[t]here is . . . no principled basis for holding that the degree of deference owed to congressional findings depends on the level of scrutiny applicable to the right at issue" (*Carhart* Br. for Pet. 25) – is fundamentally incorrect, inconsistent with almost a century of this Court's decisions, and, if adopted, will substantially undermine the structure of constitutional law.

SUMMARY OF ARGUMENT

The question of what level of deference is owed legislative findings of fact (whether made by Congress or by state legislatures) in constitutional litigation is not a new one. It divided this Court in First Amendment cases in the 1920s, and again arose in the 1940s in the Japanese-American Internment case. In the modern era, however, and contrary to the position Petitioner advances here, this

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[1] A list of interested *amici* is set forth in the Appendix. Pursuant to Rule 37.6, no counsel for a party has authored this brief and no person or entity, other than *amici* or their counsel, has made a monetary contribution to its preparation or submission. Letters of consent have been filed with the Clerk of Court.

Court has consistently refused to defer to legislative findings regarding facts and mixed questions of law and fact where, as here, the resolution of such questions serves to define the scope of a fundamental constitutional right. Put differently, when legislation is subject to heightened scrutiny because it burdens a basic right, this Court has always engaged in a searching, independent review of constitutionally relevant factual findings and conclusions. This is not to say that legislatures may not make factual findings that affect the scope of rights, or that courts should ignore such findings when they exist. To the contrary, legislatures should be encouraged to make such findings, and when courts are faced with the obligation to determine constitutional facts upon which legislative findings are based, they should accord due respect to the legislature's work. But judicial determinations of such facts should *not* be wholly deferential to legislative findings, nor are courts limited in their review to a record compiled by legislative bodies. Rather, courts must conduct an independent judicial review of legislative facts in constitutional cases and must remain free to gather and evaluate additional relevant facts, where they exist. A contrary rule would permit legislative bodies to evade and effectively overrule, through the guise of "fact-finding," the most critical decisions of this Court, thereby undermining this Court's preeminent role in constitutional interpretation mandated by *Marbury v. Madison*, 5 U.S. 137 (1803).

I. It is a basic and well-established principle of constitutional law that when a statute or other state action burdens a fundamental constitutional right, courts must engage in heightened review to determine the constitutionality of the government's actions. Such heightened review is sometimes described as "strict scrutiny," sometimes as "intermediate scrutiny," and sometimes by other descriptions such as the "undue burden" analysis set forth in *Planned Parenthood of*

Southeastern Pennsylvania v. Casey, 505 U.S. 833 (1992). Regardless, it is beyond dispute that where fundamental or other specially protected rights are implicated, judicial scrutiny is thorough, searching, and independent in determining both the applicable constitutional standard of law *and* in determining the relevant questions of fact and mixed questions of fact and law, which ultimately control the reviewing court's resolution of the constitutional claim.

The reason that heightened scrutiny mandates independent judicial review is that no other form of review can preserve the judiciary's preeminent role as interpreter of the Constitution, or duly recognize that the purpose of the Bill of Rights is to restrict, not enhance, legislative power. Petitioner's position in favor of deference in *all* cases, regardless of the constitutional nature of the rights and findings at issue, ignores these basic constitutional principles and threatens to empower legislatures through the guise of making "findings of fact" to overrule this Court's leading constitutional decisions, including *Brown v. Board of Education*, 347 U.S. 483 (1954) and *United States v. Eichman*, 496 U.S. 310 (1990).

This searching, independent review applies to *all* fundamental and other specially protected rights, and applies to *all* legislative conclusions and predicate findings of fact bearing on the definition and scope of the Constitution, whether made by Congress or by state legislatures. Insofar as Petitioner contends that Congress is due special deference not owed state legislatures (it is unclear whether Petitioner continues to defend this position), such an argument has no basis in this Court's jurisprudence, fails to achieve constitutional uniformity, and runs contrary to fundamental tenets of federalism.

II. The right to choose an abortion recognized in *Roe v. Wade*, 410 U.S. 113 (1973) and reaffirmed in *Casey*, is a specially protected constitutional right. As such, the level of scrutiny applicable to abortion regulations, including that

inherent in the "undue burden" test announced in the Joint Opinion in *Casey*, 505 U.S. at 876, is heightened scrutiny. Petitioner's reliance on *Turner Broadcasting System, Inc. v. FCC*, 520 U.S. 180 (1997) (*Turner II*), a case in which this Court did *not* employ heightened scrutiny, for the proposition that congressional findings of fact are owed deference regardless of the fundamentality of the constitutional rights at stake, is misplaced in two respects.

First, the undue burden test is not a form of intermediate scrutiny. Rather, notwithstanding this Court's recognition that governments possess powerful, compelling interests in regulating abortion, the undue burden test remains a form of strict scrutiny. Second, even if the undue burden test is roughly comparable to an intermediate level of review, it does *not* resemble the highly deferential form of intermediate scrutiny applied in *Turner II*. This Court's jurisprudence confirms that intermediate scrutiny comes in many forms, from the highly searching review employed in gender discrimination cases such as *United States v. Virginia*, 518 U.S. 515 (1996) and in modern commercial speech cases like *Lorillard Tobacco Co. v. Reilly*, 533 U.S. 525 (2001) and *Thompson v. Western States Medical Center*, 535 U.S. 357 (2002), to the highly deferential form of review employed in *Turner II* and other cases involving content-neutral regulations of speech or symbolic conduct such as *United States v. O'Brien*, 391 U.S. 367 (1968) and *Ward v. Rock Against Racism*, 491 U.S. 781 (1989). This Court's decision in *Casey*, striking down Pennsylvania's spousal notification requirement, and its recent decision in *Stenberg v. Carhart*, 530 U.S. 914 (2000), unequivocally confirm that the undue burden test is not a deferential form of scrutiny.

III. Where congressional findings of fact are determinative of the scope and reach of specially protected constitutional rights, courts must engage in an *independent* review of the relevant questions, including relevant constitutional and legislative facts. Constitutional facts are

invariably mixed questions of fact and law, the resolution of which serves to interpret the Constitution. Courts not legislatures uniformly retain control over the disposition of such questions. We do not suggest that legislatures have no role in finding facts relevant to constitutional interpretation, or that courts should ignore such findings. To the contrary, legislatures remain free to compile factual records supporting their enactments and, given the vast resources at the disposal of modern legislatures, and their institutional capacities to sponsor and supervise empirical research, courts should encourage the creation of such records. When engaging in independent review, courts should consider carefully, and give due respect to, the records and findings elected legislatures have made. Courts cannot, however, grant unfettered deference to legislative action, nor can they restrict their review to legislative records. Rather, courts must remain free to compile judicial records in litigation, engage in independent research, and rely on submissions of *amici*, in addition to reviewing whatever materials are compiled by legislative bodies. Any other approach would abdicate the judiciary's role as enforcer of constitutional constraints on legislative power, thereby leaving legislative foxes guarding the constitutional henhouse.

ARGUMENT

I. LEGISLATIVE ENACTMENTS THAT TRIGGER HEIGHTENED SCRUTINY BECAUSE THEY BURDEN SPECIALLY PROTECTED RIGHTS ARE SUBJECT TO SEARCHING, *INDEPENDENT* JUDICIAL REVIEW ON ALL ISSUES, INCLUDING QUESTIONS OF CONSTITUTIONAL FACT

At the heart of Petitioner's argument to this Court is the following proposition: "There is . . . no principled basis for holding that the degree of deference owed to congressional findings depends on the level of scrutiny applicable to the

right at issue."[2] That proposition is astonishingly incorrect. Indeed, it is the very essence of heightened judicial scrutiny that it is not only searching, but that it is *independent*, in contrast to the "normal" undemanding and deferential review courts accord legislation. That is precisely why heightened scrutiny is limited to situations where legislation has burdened fundamental or specially protected rights and is, therefore, presumptively suspect. To accept Petitioner's position in these cases would be to collapse the well-established tiers of review and, in so doing, eviscerate judicial protection for fundamental constitutional liberties.

A. This Court Has Long Recognized That Heightened Scrutiny Constitutes A Form Of Searching, *Independent* Judicial Review

The question of what level of deference should be accorded to legislative findings has arisen regularly since the very beginnings of this Court's modern jurisprudence of fundamental rights. In *Gitlow v. New York*, 268 U.S. 652 (1925), faced with a First Amendment challenge to New York's Criminal Anarchy Statute, a majority of this Court affirmed Benjamin Gitlow's conviction based on his involvement in the publication of the "Left Wing Manifesto." According to the majority, by enacting the present statute: "the State has determined, through its legislative body, that utterances advocating the overthrow of organized government by force, violence and unlawful means, are so inimical to the general welfare and involve such danger of substantive evil that they may be penalized in the exercise of its police power. That determination must be given great weight. Every presumption is to be indulged in favor of the validity of the statute." *Id.* at 668. Two years later, this Court, relying on this statement in *Gitlow*, proceeded to also affirm Anita Whitney's conviction under

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[2] *Carhart* Br. for Pet. 25.

California's Criminal Syndicalism Act. *See Whitney v. California*, 274 U.S. 357, 371 (1927). This decision elicited a separate opinion by Justice Brandeis, joined by Justice Holmes, which is widely considered to be one of the most influential opinions in the history of this Court and which has been described by Professor G. Edward White as "launch[ing] the project of bifurcated constitutional review." G. Edward White, *The First Amendment Comes of Age: The Emergence of Free Speech in Twentieth-Century America*, 95 MICH. L. REV. 299, 326 (1996).

In *Whitney*, Justice Brandeis has this to say about the majority's holding on deference: "where a statute is valid only in case certain conditions exist, the enactment of the statute cannot alone establish the facts which are essential to its validity." *Id.* at 374 (Brandeis, J., concurring). Later, Brandeis emphasized that a legislative declaration regarding social danger "does not preclude enquiry into the question whether, at the time and under the circumstances, the conditions exist which are essential to validity under the Federal Constitution." *Id.* at 379. In short, Brandeis recognized that if individual liberties were to be preserved, independent judicial review of *facts* was essential. This Court has since acknowledged that "there is little doubt that subsequent opinions [of the Court] have inclined toward the Holmes-Brandeis rationale." *Dennis v. United States*, 341 U.S. 494, 507 (1951); *see also Brandenburg v. Ohio*, 395 U.S. 444 (1969) (overruling *Whitney*).

In modern times, Justice Brandeis's basic insight in *Whitney*, that when fundamental liberties are at stake independent judicial scrutiny is essential, has been realized through the concept of tiers of scrutiny. In a wide variety of constitutional contexts, this Court has established various substantive tests that differ in their rigor depending on the depth of the constitutional right involved. Hence, in Due Process, Equal Protection, and First Amendment cases, this Court ordinarily applies strict scrutiny when fundamental

or specially protected rights are implicated, but only rational basis review when the right is non-fundamental. *See generally* Ashutosh Bhagwat, *Purpose Scrutiny in Constitutional Analysis*, 85 CAL. L. REV. 297 (1997). This "tailoring" analysis is principally empirical, and courts' deference to legislative fact-finding diminishes in direct proportion to the fundamentality of the right. *See generally*, Gerald Gunther, *The Supreme Court, 1971 Term – Foreword: In Search of Evolving Doctrine on a Changing Court: A Model for a Newer Equal Protection*, 86 HARV. L. REV. 1, 33-36 (1972). Under strict scrutiny, the government must demonstrate that the law is narrowly tailored to achieve a compelling government interest. Under rational basis review, courts determine merely whether the law is rationally related to a legitimate government interest. Simply put, tiered scrutiny operates on a sliding scale such that the more fundamental the right, the greater the degree of scrutiny courts bring to bear in evaluating alleged infringements of those rights.

Unfortunately, this constitutional terrain is not entirely free of ambiguity. Although basic doctrine often distinguishes in theory between strict scrutiny and rational basis review, the actual practice by which courts safeguard basic liberties is rather more complicated. Two complications, in particular, are worthy of note. First, over the last thirty years, this Court has regularly departed from a strict and categorical approach to two-tiered scrutiny. The clearest example is this Court's adoption of intermediate scrutiny in several constitutional contexts, including gender discrimination, regulation of commercial speech, and content-neutral regulations of symbolic conduct or speech. *See, e.g., Craig v. Boren*, 429 U.S. 190 (1976) (gender); *Cent. Hudson Gas & Elec. Corp. v. Pub. Serv. Comm'n of N.Y.*, 447 U.S. 557 (1980) (commercial speech); *O'Brien*, 391 U.S. 367 (symbolic conduct); *Rock Against Racism*, 491 U.S. 781 (content-neutral speech regulation).

The second complication is that in different constitutional contexts the intermediate scrutiny test is manifested in different ways. In *United States v. Virginia* (the VMI case), this Court applied intermediate scrutiny but noted that the government must have an "exceedingly persuasive" justification for discriminating on the basis of gender. 518 U.S. at 531. In contrast, the test applied in symbolic conduct cases such as *O'Brien* is notably less rigorous, and has been described as not being an "enhanced level of scrutiny" at all, but rather as resembling rational basis review. *See Barnes v. Glen Theatre, Inc.*, 501 U.S. 560, 578-579 (1991) (Scalia, J., concurring in the judgment). Intermediate scrutiny, as a practical matter then, has become something of a catchall for a constitutional domain ranging from rational basis analysis with bite to strict scrutiny that is not invariably fatal in fact. The designation of "intermediate scrutiny" alone, therefore, proves to be neither exact nor especially helpful.

Regardless of precise terminology, however, in the modern era this Court has consistently applied *heightened* scrutiny to laws that burden specially protected rights in a searching and independent manner, without deferring in any way to legislative judgments of fact or law. This tendency is most obvious in First Amendment cases. In *Landmark Communications, Inc. v. Virginia*, 435 U.S. 829, 844 (1978), this Court specifically reversed the Supreme Court of Virginia's deference to legislative fact-finding, holding that "[d]eference to a legislative finding cannot limit judicial inquiry when First Amendment rights are at stake." *Id.* at 844 (*citing Pennekamp v. Florida*, 328 U.S. 331, 335 (1946) ("[The Court is] compelled to examine for [itself] the statements in issue and the circumstances under which they were made.")). According to the *Landmark* Court, if legislative findings were accorded deference, "the scope of freedom of speech and of the press would be subject to legislative definition and the function of the First

Amendment as a check on legislative power would be nullified." *Id.* at 844.

Just recently, a plurality of the Court in *Randall v. Sorrell*, 126 S.Ct. 2479 (2006), rejected Vermont's claim that courts should be deferential to state legislative findings of fact regarding whether campaign contribution limits "prevented candidates . . . from 'amassing the resources necessary for effective [campaign] advocacy,'" and thus "are too low and too strict to survive First Amendment scrutinty." *Id.* at 2492 (*quoting Buckley v. Valeo*, 424 U.S. 1, 21, (1976 (per curiam)). Justice Breyer duly recognized that legislatures are "better equipped to make such empirical judgments, as legislators have "'particular expertise' in matters related to the costs and nature of running for office." *Id.* (*quoting McConnell v. Fed. Election Comm'n*, 540 U.S. 93, 137 (2003)). Neverthless, and despite the virtually unique expertise possessed by legislators in this particular context, Justice Breyer found that it was incumbent upon courts to exercise "independent judicial judgment," and "review the [factual] record independently and carefully" to ensure that the statutory restrictions at issue comported with the Constitution. *Id.*

The issue of deference to legislative findings – in this case, congressional findings – also arose in *Sable Communications of California, Inc. v. FCC*, 492 U.S. 115 (1989). In *Sable*, the government argued that this Court should defer to congressional fact findings regarding the necessity of a complete ban on speech to achieve Congress's regulatory interests. This Court's response, in an opinion this part of which was unanimous, was to unambiguously reject that argument, stating that "whatever deference is due legislative findings would not foreclose our independent judgment of the facts bearing on an issue of constitutional law" (though the Court went on to recognize that Congress had in any event made no findings on the relevant question). *Id.* at 129. Even more recently, in *Reno v. ACLU*, 521 U.S. 844, 875 (1997), this Court reaffirmed its holding in

Sable in which "this Court rejected the argument that we should defer to the congressional judgment" regarding the necessity of a particular act of legislation.

This Court has also explicitly recognized the need for nondeferential review outside the First Amendment context. Notably, in *United States v. Virginia*, this Court reversed the lower court's deference to legislative conclusions regarding the equality of all-female and all-male educational programs, stating that "[t]he Fourth Circuit plainly erred in exposing Virginia's VWIL plan to a deferential analysis for 'all gender-based classifications today' warrant 'heightened scrutiny.'" 515 U.S. at 555-556 (*quoting J.E.B. v. Alabama ex rel. T.B.*, 511 U.S. 127, 136 (1994)). *United States v. Virginia*, it should be noted, was a case involving intermediate scrutiny, and this Court clearly stated that such scrutiny constitutes "heightened scrutiny" requiring nondeferential analysis. *Id.*

Finally, while the above cases clearly establish the proposition that heightened scrutiny contemplates some degree of independent, nondeferential review, they are merely the tip of the iceberg. In a myriad of cases, across the range of constitutional analysis, this Court has applied heightened scrutiny in an independent and searching manner, often with the consequence of striking down legislation, and without expressly addressing the question of deference. *See, e.g., City of Richmond v. J.A. Croson*, 488 U.S. 469 (1989); *Lucas v. South Carolina Coastal Council*, 505 U.S. 1003 (1992); *Western States*, 535 U.S. 357. All serve to confirm the basic logic of tiered scrutiny - th at different levels of scrutiny are accorded different, correspoding levels of deference such that the greater the core right implicated the more searching the judicial review must be.

B. *Independent* Review Extends To Questions Of Legislative And Constitutional Fact

As demonstrated above, in the modern era, this Court has consistently held that when a legislature burdens fundamental freedoms and thereby triggers heightened

judicial scrutiny, such scrutiny must be searching as well as independent and nondeferential. Furthermore, the concept of independent review includes review of purely legal questions as well as factual ones. There is another, equally compelling reason that deference to legislative fact-finding is inappropriate in constitutional cases. Specifically, the factual issues toward which deference is claimed in constitutional litigation are typically not questions of adjudicative fact, but rather questions of legislative, constitutional fact, the resolution of which bears directly on the definition and scope of core constitutional rights and, thus, the Constitution itself.

The question whether a health exception to a regulation of pre-viability abortions is necessary raises an issue of "legislative fact." Professor Kenneth Culp Davis coined the term "legislative fact" in an effort to distinguish such facts from "adjudicative facts." Kenneth Culp Davis, *An Approach to Problems of Evidence in the Administrative Process*, 55 HARV. L. REV. 364, 402-03 (1942). Adjudicative facts are those facts particular to a specific litigated dispute. Legislative facts, according to the Advisory Committee Note to Federal Rule of Evidence 201(a), "are those which have relevance to legal reasoning and the lawmaking process, whether in the formulation of a legal principle or ruling by a judge or court or in the enactment of a legislative body." FED. R. EVID. 201(A) (Advisory Committee Note). In general, the rules of evidence for finding facts that form the basis for creation of law and policy differ from the rules for finding facts specific to parties in a particular case. *See* Davis, *supra*, at 402; *see also* David L. Faigman, *"Normative Constitutional Fact-Finding": Exploring the Empirical Component of Constitutional Interpretation*, 139 PA. L. REV. 541, 552-56 (1991). Whereas adjudicative facts are decided by triers of fact and concern only the immediate parties to the dispute, legislative facts transcend particular cases and must be decided by courts as a matter of law.

Facts that are employed to substantiate the validity of legislation are, by definition, "legislative facts." When such legislation burdens fundamental rights, the legislature's factual premises must be subjected to independent judicial scrutiny. Logic permits no contrary conclusion, if judicial review is to have any meaning at all. In *Casey*, this Court invalidated the spousal notification provision on the ground that in some small but significant percentage of cases this requirement would subject women seeking to terminate their pregnancies to domestic abuse. *See Casey*, 505 U.S. at 888-93. The authors of the Joint Opinion were persuaded by social science research indicating that some women would be battered if they had to comply with this regulation. *Id.* This factual finding was based on both the trial record and research authority provided by *amici*. *Id.* The Court found this fact at the "legislative" level, in that the finding applied to all cases and, in so doing, established a uniform constitutional rule. *Id.* As a consequence, and based on its independent legislative-fact review, this Court ruled, as a matter of law, that spousal notification provisions placed a substantial obstacle in the path of women seeking to terminate their pregnancies. Almost certainly, this Court did not mean to leave open the possibility that a particular legislature or lower court could overturn its decision merely by making "findings" that the risk of domestic violence is in fact *de minimis*.[3]

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[3] Petitioner argues that Congress has the authority to revisit this Court's decisions when the facts on which those decisions depend have changed. *Amici* do not disagree with this general proposition. Indeed, as we argue below (Part III), Congress's vast capacity to find facts should be encouraged. If Congress believes that subsequent developments cast doubt on the factual premises of one of this Court's decisions, then it, as a coordinate branch of government, is free to act accordingly. Nonetheless, it remains this Court's obligation to independently review such actions, as well as any accompanying fact-finding, when they infringe fundamental liberties. *Cf. Roper v. Simmons*, 543 U.S. 551 (2005) (Missouri Supreme

Beyond the legislative character of the essential facts in these cases, there is an even more fundamental, equally compelling reason for close judicial scrutiny. Petitioner argues that the question of whether a health exception is constitutionally necessary is a "pure fact" that does not implicate constitutional values. We disagree. The question of the need for a health exception is a *constitutional* fact. Specifically, the answer to this factual question critically affects the meaning of a guarantee of basic liberty, which this Court has found to exist. Constitutional facts are invariably mixed questions of fact and law, the resolution of which serves to interpret the Constitution and warrants independent nondeferential review. *See, e.g., Bose Corp. v. Consumers Union*, 466 U.S. 485, 501 (1984). Indeed, virtually every constitutionally relevant fact helps define the scope and meaning of the Constitution itself. Examples are numerous. *See Brown*, 347 U.S. 483 (the effects of segregation); *Roe*, 410 U.S. 113 (the point at which a fetus becomes viable); *Lee v. Weisman*, 505 U.S. 577 (1992) (the psychological coercion inherent in a graduation invocation and benediction); *New York v. Ferber*, 458 U.S. 747 (1982) (the effects of child pornography); *Edwards v. Aguillard*, 482 U.S. 578 (1987) (the secular basis, if any, of creation science); *Miller v. California*, 413 U.S. 15 (1973) (the artistic or literary value of alleged obscenity). Because constitutional facts are mixed questions of fact and law, and because they profoundly shape the legal effects of constitutional provisions, they must be resolved as a matter of law. *See Bose*, 466 U.S. at 501. Courts, not legislatures or other finders of fact, always retain control over the disposition of such questions of law at every level of the judicial process.

Court distinguished this Court's precedent in concluding that standards of decency had evolved such that executing someone who had committed a capital offense as a juvenile no longer comported with Eighth Amendment guarantees).

See generally David L. Faigman, *Fact-Finding in Constitutional Cases* in HOW LAW KNOWS (Austin Sarat et al., eds. 2006). As such, under heightened scrutiny, independent review of constitutional fact-finding is an integral element of this Court's constitutional obligations.

There is a basic illogic to Petitioner's contention that federal courts should be largely deferential to a legislature's fact-finding in abortion cases. The undue burden standard is the applicable test for assessing the constitutionality of legislative actions under the Constitution, just as strict scrutiny is the test for assessing the constitutionality of race-based legislative classifications. Regulations that implicate this core, specially protected right, are subject to heightened scrutiny. Congress is thus prohibited from passing a law that places "a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." *Casey*, 505 U.S. at 877. Yet Petitioner asserts that courts must defer to Congress's factual findings regarding the evidence that dictates whether its own law creates a substantial obstacle. But it would not be much of a test of congressional action if courts had to defer to Congress's judgment of whether the disputed law passes the test. *Cf. Korematsu v. United States*, 323 U.S. 214, 245 (1944) (Jackson, J., dissenting).

In most constitutional cases involving basic rights, the guarantee of the right itself can be manipulated by alternative findings of fact. For that reason, just as a legislature could not alter the scope of Equal Protection guarantee identified in *Brown v. Board of Education* by finding as a matter of fact that segregated schools *advantage* African-Americans, Congress cannot evade the constitutional guarantees of *Roe* and *Casey* by finding, unilaterally and categorically, that its laws do not pose a health risk to women. *See Stell v. Savannah-Chatham County Bd. of Educ.*, 333 F.2d 55 (5th Cir. 1964), *rev'g Stell v. Savannah-Chatham County Bd. of Educ.*, 220 F. Supp. 667 (S.D. Ga. 1963) (reversing district court's finding of fact that

school segregation does not injure black children and concluding that the effects of segregation as determined in *Brown* are unassailable legislative facts).

Structural separation of powers also suggests that whether Congress has violated the Constitution in this case cannot depend on Congress's own determination of this question. Chief Justice John Marshall's words in *Marbury v. Madison* apply in full force to this matter:

> To what purpose are powers limited, and to what purpose is that limitation committed to writing, if these limits may, at any time, be passed by those intended to be restrained? The distinction, between a government with limited and unlimited powers, is abolished, if those limits do not confine the persons on whom they are imposed, and if acts prohibited and acts allowed, are of equal obligation....

Marbury, 5 U.S. at 176-77. Marshall then added these famous words: "It is emphatically the province and duty of the judicial department to say what the law is." *Id.* In the instant case, the constitutionally relevant findings of fact will effectively "say what the law is," and thus cannot be left to Congress alone to determine.

Because the empirical question regarding the necessity of a health exception is tightly connected to the due process right itself - and largely dictates the constitutional issue of whether the law constitutes an "undue burden" - it presents a mixed question of fact and law, or a *constitutional* fact, which must be subjected to independent judicial review. Because its resolution inevitably affects the definition of the core right to abortion, the fact-finding necessary to determine whether a health exception is needed (as well as Congress's conclusion that it is not) is a basic component of the judiciary's obligations under the Constitution. In finding that a health exception is, as a matter of fact, never

medically necessary, Congress has essentially defined out of existence a critical component of a basic right this Court has recognized as a matter of law and, more fundamentally, has concluded for itself that the underlying right is not burdened. The ultimate conclusion whether the law constitutes an "undue burden," however, must be a product of this Court's independent legal judgment.

C. Congressional Fact Findings Warrant The Same Deference As State Legislative Findings

Petitioner originally argued that special deference is due legislative findings of fact in this case because it involves a challenge to a federal statute enacted by Congress, rather than to state legislative action. *See Carhart* Pet. 15 (distinguishing *Stenberg* because it was a "case in which there was no federal statute at issue"). In its merits brief, Petitioner does not clearly pursue this argument, indicating that it has perhaps been abandoned. However, Petitioner's brief does suggest, somewhat obliquely, that special "binding" deference is due because it is *Congress* (presumably in contrast to state legislatures) that has made the factual findings here (*see Carhart* Br. for Pet. 6, 10, 13, 21-23, 25-26 & n.7), and attempts to again distinguish *Stenberg* on the grounds that "the statute at issue here is an Act of Congress accompanied by congressional findings." *Id.* at 43. Any argument that congressional findings are owed special deference not due to the findings of state legislatures is contrary to fundamental tenets of federalism and has no basis in the jurisprudence of this Court.

The reason Congress and state legislatures should not be treated differently when analyzing constitutionality is simple. When duly elected state legislatures act within their proper sphere of legislative authority, their enactments are entitled to the same respect, and possess the same democratic legitimacy, as congressional statutes. That is a basic assumption of our federal system, which Petitioner's argument ignores. Furthermore, like Congress, state

legislatures control institutional mechanisms, such as legislative hearings, which can be used to gather information. Petitioner's position turns federalism on its head by empowering Congress, and disempowering the states, to legislate in areas of moral regulation, such as abortion and indecency, where state authority has traditionally been considered preeminent.[4]

If Petitioner's deferential standard of review were adopted in this case, it would, therefore, apply with equal force to state and federal legislative fact findings. As a consequence, different legislatures could find different facts predicated on essentially the same record and these disparate findings would be upheld by the courts. In other words, the deferential standard advocated by Petitioner might require this Court to sustain conflicting findings regarding whether a particular regulation creates an undue burden because, in close cases, both empirical positions could be "reasonable and supported by substantial evidence." *See United States v. Williams*, 81 F.3d 1434, 1437 (7th Cir. 1996) (noting that when a determination is left to the discretion of other decision makers, it is possible for them to come to different conclusions and for the appellate courts to affirm variable outcomes under a deferential standard of review). Such a result would leave different jurisdictions with inconsistent constitutional practices notwithstanding the fact that the empirical issue, or the relevant constitutional fact, is identical in each of them.[5]

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[4] This is not to say that federal and state legislation must always be treated similarly. Certainly, in areas such as foreign affairs and national security, where the Constitution grants special powers to the national government, and where separation of powers dictates a reduced judicial role, special deference to Congress may be appropriate. This principle distinguishes *Rostker v. Goldberg*, 453 U.S. 57 (1981), one of the few cases Petitioner relies on for its deference argument.

[5] This is unlike the situation in which inconsistency results because the facts differ from place to place. This typically occurs in cases in which the

Petitioner fails to advance any persuasive reason why this Court should adopt a rule that so fundamentally undermines constitutional uniformity.

Indeed, this Court's holding in *Stenberg* implicitly recognized the danger of allowing inconsistent findings and compels the conclusion that the necessity of a health exception must be found at the level of constitutional fact – not amenable to alteration by the fact-finding of individual legislatures. *See Stenberg*, 530 U.S. at 934. Courts of Appeal have explicitly recognized the need for facts to be found at the legislative level when evaluating abortion legislation. *See, e.g., Hope Clinic v. Ryan*, 195 F.3d 857, 884 (7th Cir. 1999) (Posner, J., dissenting) ("The health effects of partial birth abortion should indeed be treated as a legislative fact, rather than an adjudicative fact, in order to avoid inconsistent results arising from the reactions of different district judges...to different records."), *vacated by* 530 U.S. 1271 (2000); *A Woman's Choice - East Side Women's Clinic v. Newman*, 305 F.3d 684, 688 (7th Cir. 2002) ("[C]onstitutionality must be assessed at the level of legislative fact, rather than adjudicative fact determined by more than 650 district judges. Only treating the matter as one of legislative fact produces the nationally uniform approach that *Stenberg* demands."). Courts simply cannot defer to legislative fact-finding where, as here, a uniform constitutional rule is indicated.[6]

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relevant constitutional fact is an adjudicative fact. Under The *Miller* test, for example, it would be possible for the same photograph to be found obscene in one locale but not another, since one prong of the test is tied to "contemporary community standards." *Miller*, 413 U.S. at 24.

[6] An analogous situation was presented in *Lockhart v. McCree*, 476 U.S. 162 (1986). Although this Court did not decide the case based on the factual issue, Justice Rehnquist observed, "[w]e are far from persuaded, however, that the 'clearly erroneous' standard of Rule 52(a) applies to the kind of 'legislative' facts at issue here." He explained, "[t]he difficulty with applying such a standard to 'legislative' facts is evidenced here by

II. THE RIGHT TO CHOOSE AN ABORTION IS A CORE CONSTITUTIONAL RIGHT, WHICH TRIGGERS HEIGHTENED SCRUTINY

Aside from Petitioner's clearly incorrect claim that courts must defer to congressional findings regardless of the level of scrutiny they apply, the primary basis for its claim of deference is that "the undue-burden standard . . . closely resembles an intermediate-scrutiny standard" (*Carhart* Br. for Pet. 25), such that deferential review applies. That argument is plainly wrong in two respects. First, the undue burden standard is not a form of intermediate scrutiny, but rather a different test altogether and one that requires heightened scrutiny by this Court. Second, even if the undue burden standard might be considered comparable to *some* forms of intermediate scrutiny, it certainly does not resemble the highly diluted form of scrutiny applied in the two *Turner* cases Petitioner cites in support of its substantial deference standard.[7]

A. The Undue Burden Test Constitutes A Form Of Heightened Judicial Scrutiny

It is clear, as a simple matter of linguistics, that the undue burden test is not merely another way of describing intermediate scrutiny. If this Court had wanted to employ intermediate scrutiny in the abortion context, it certainly knew what words would have accomplished that result. The basic statement of intermediate scrutiny is well described in the case law: a law passes intermediate scrutiny if it is substantially related to an important government interest. *See Craig*, 429 U.S. at 197-98. Applying

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the fact that at least one other Court of Appeals, reviewing the same social science studies as introduced by McCree, has reached a conclusion contrary to that of the [court below]." *Lockhart*, 476 U.S. at 170 (*citing Dunagin v. City of Oxford*, 718 F.2d 738, 748 n.8 (5th Cir. 1983) (*en banc*) (plurality opinion of Reavley, J.)).

[7] *See Carhart* Br. for Pet. 21-22, 24-26.

this test, a reviewing court is obligated to evaluate the importance of the government's stated objectives and assess whether the means are substantially likely to achieve those ends. The undue burden standard posits a different question. It asks whether the government's action creates a substantial obstacle to the exercise of the abortion right. These two tests call for distinct inquiries and there is no authority whatsoever to suggest that the undue burden test is functionally equivalent to intermediate scrutiny.

It is also clear as a jurisprudential matter that Petitioner errs in equating the undue burden standard with intermediate scrutiny: Petitioner has undervalued the underlying right implicated by the disputed law. Close inspection of *Casey* and *Stenberg* indicates that the depth of the right of reproductive choice is comparable to that of traditional fundamental rights protected by strict scrutiny. In *Roe v. Wade*, this Court held that privacy, which included a woman's right to terminate her pregnancy prior to viability, was located in the Due Process Clauses of the Fifth and Fourteenth Amendments. The Court went on to treat this right as fundamental and sufficient to trigger strict scrutiny, concluding that only at viability does the State's interest become sufficiently compelling to override the right. *See Roe*, 410 U.S. at 153-54. Although this Court has substituted the undue burden test for the trimester framework, it has never intimated that its view of the fundamentality of the underlying right has changed. The Joint Opinion in *Casey* and the majority in *Stenberg* repeatedly expressed their fidelity to this "central tenet" of *Roe v. Wade*. *Casey*, 505 U.S. at 871 ("The woman's right to terminate her pregnancy before viability is the most central principle of *Roe v. Wade*. It is a rule of law and a component of liberty we cannot renounce."); *Stenberg*, 530 U.S. at 920 ("[T]he Constitution offers basic protection to the woman's right to choose."). Thus, this Court's established (and, in this case, unchallenged) precedents clearly hold that the

right of reproductive choice was, and is, a specially protected core constitutional right.

The reason that the *Casey* plurality substituted the undue burden test for traditional strict scrutiny was not that it was down-grading the core nature of the right, but rather that it considered the undue burden test to constitute "the appropriate means of reconciling the State's interest with the woman's constitutionally protected liberty." *Casey*, 505 U.S. at 875-76 (expressly noting that the *Roe* Court "undervalue[d] the State's interest in the potential life within the woman."). At no point does *Casey's* Joint Opinion or *Stenberg* remotely suggest that a woman's right is less than fundamental or that *Roe's* holding to that effect is in any way diminished or disapproved. Thus, notwithstanding *Casey's* modification of the applicable test, the underlying right continues to be counted as a specially protected constitutional right that triggers close judicial scrutiny of laws that would infringe it.[8]

B. Petitioner's Cases In Support Of Deference Are Distinguishable As They Did Not Involve True, Heightened Scrutiny

Even assuming the undue burden test is roughly comparable to an intermediate level of review, Petitioner's proposed standard is considerably more deferential than that applied under ordinary intermediate scrutiny. Petitioner's deferential standard is employed in constitutional cases in which core constitutional rights are only incidentally infringed and not, as here, the target of legislative action. Petitioner asserts that this Court should

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[8] Indeed, despite its surface claims to the contrary, Petitioner implicitly concedes the fundamentality of the right of choice. Repeatedly, Petitioner defends Congress by citing "the government's compelling interests" that are advanced by the statute. *See Carhart* Br. for Pet. 13; *see also id.* at 11, 41, 42. This, of course, is the language of strict, not intermediate scrutiny.

defer to congressional findings regarding the necessity of a health exception so long as "Congress has drawn reasonable inferences based on substantial evidence." *Carhart* Br. for Pet. 21 (*quoting Turner II*, 520 U.S. at 195 (*quoting Turner Broad. Sys., Inc. v. FCC*, 512 U.S. 622, 666 (1994) (*Turner I*))). But this language is inapposite in the cases at hand, because neither *Turner I* nor *Turner II* employed the kind of heightened scrutiny applicable to abortion regulations.

The deference applied in the *Turner* cases must be understood against the backdrop of this Court's proper and longstanding reluctance to impose its opinions on Congress concerning questions of economic policy, at least when congressional actions do not *directly* burden constitutional rights. When a regulation *does* directly burden a constitutional right, however, this Court does not defer to Congress, even if the regulation might be described as an "economic" one. The *Turner* deference standard is thus doubly inapplicable here, both because the statute here is not economic, and because it directly burdens a basic right.

The fundamental premise underlying the deference accorded to Congress in *Turner* is the idea that, absent a direct burden on constitutional rights, economic policy must be formulated by elected legislatures, not the courts. As Justice Holmes recognized over a century ago, "the constitution is not intended to embody a particular economic theory, . . . it is made for people of fundamentally differing views." *Lochner v. New York*, 198 U.S. 45, 75-76 (1905) (Holmes, J., dissenting). Since the abandonment of *Lochner* in 1937, this Court has consistently recognized that the only legitimate means to reconcile these divergent views is for fundamental economic policy decisions to be made legislatively. This Court has also consistently recognized, however, that when Congress *does* burden fundamental rights, deference is not in order. *Compare United States v. Carolene Prod. Co.*, 304 U.S. 144, 152 (1937) ("regulatory legislation affecting ordinary commercial transactions is not

to be pronounced unconstitutional unless in the light of the facts made known or generally assumed it is of such a character as to preclude the assumption that it rests upon some rational basis within the knowledge and experience of the legislators") *with id.* at 153 n.4 ("There may be narrower scope for operation of the presumption of constitutionality when legislation appears on its face to be within a specific prohibition of the Constitution, such as those of the first ten amendments, which are deemed equally specific when held to be embraced within the Fourteenth.").

The two *Turner* cases involved a congressional effort to implement an economic policy reconciling the needs of the cable television and broadcast industries, which did *not* directly burden a constitutional right. Both cases concerned portions of the Cable Television Consumer Protection and Competition Act of 1992, requiring cable television systems to devote a portion of their channels to the re-transmission of local broadcast television stations. Reasoning that the Act was a content-neutral regulation with an incidental effect on speech, *Turner I* applied the test laid out in *United States v. O'Brien*, 391 U.S. 367. Under *O'Brien*, a content-neutral regulation will be sustained if "it furthers an important or substantial governmental interest; if the governmental interest is unrelated to the suppression of free expression; and if the incidental restriction on alleged First Amendment freedoms is no greater than is essential to the furtherance of that interest." *O'Brien*, 391 U.S. at 377. *O'Brien's* approach was itself deferential. Such deference followed from the fact that the challenged law did not target free speech, but rather was a content-neutral regulation of non-speech activity that only incidentally affected expression. *See* Ashutosh Bhagwat, *Of Markets and Media: The First Amendment, The New Mass Media, and the Political Components of Culture*, 74 N.C. L. REV. 141, 169-70 (1995). This deferential *O'Brien* standard, applied again in *Turner II* after remand, provides the necessary context for understanding Justice Kennedy's

observation that "deference must be accorded to [Congressional findings to avoid infringing on] traditional legislative authority to make predictive judgments when enacting nationwide regulatory policy." *Turner II*, 520 U.S. at 196.

As noted above, however, the highly deferential form of review applied in *O'Brien* (and in the related line of cases, epitomized by *Ward v. Rock Against Racism*, 491 U.S. 781, which involve time, place, and manner regulations of the public forum) has *not* been applied in other contexts where true heightened scrutiny is required. This lack of deference is most obvious in cases such as *Sable*, *Reno v. ACLU*, and *Croson*, applying strict scrutiny. *See* Part I.A., *supra*. Indeed, in the *Turner* cases themselves, this Court recognized that deference would not have been due if the congressional legislation at issue directly targeted a core right. Justice Stevens's concurrence in *Turner I* makes the matter clear: "[T]he factual findings accompanying economic measures that are enacted by Congress itself and that have only incidental effects on speech merit greater deference than those supporting content-based restrictions on speech. . . ." *Turner I*, 512 U.S. at 671 n.2 (Stevens, J., concurring). Again, in *Turner II*, Justice Stevens wrote briefly in his concurrence to reiterate that:

> [T]he policy judgments made by Congress in the enactment of legislation that is intended to forbid all the abuse of monopoly power are entitled to substantial deference, [even when] the attempt to protect an economic market imposes burdens on communication. *If this statute regulated the content of speech rather than the structure of the market, our task would be quite different.*

Turner II, 520 U.S. at 225 (Stevens, J., concurring) (emphasis added) (internal citations omitted).

Further, contrary to Petitioner's claims it is clear that even in cases applying what is described as "intermediate scrutiny," this Court does not always defer to legislative findings. This is most obvious in Equal Protection cases applying intermediate scrutiny to gender classifications, where this Court has paid little heed to legislative findings. *See Craig*, 429 U.S. at 200-01 (dismissing statistics offered to support state legislation imposing a different minimum age, based on gender, for purchasing beer as weak, inaccurate, and failing to closely serve the objectives of the legislation); *United States v. Virginia*, 518 U.S. at 542-43 (dismissing the testimony of Virginia's experts that the admission of women to the all-male Virginia Military Institute would be so radical as to destroy the program as an unproven judgment, "a prediction hardly different from other 'self-fulfilling prophec[ies]' once routinely used to deny rights or opportunities.") (citations omitted). Similarly, in recent cases applying intermediate scrutiny to regulations of commercial speech, this Court has independently reviewed the record and refused to defer to legislative enactments. *See, e.g., Lorillard*, 533 U.S. 525; *Western States*, 535 U.S. 357.

Indeed, Petitioner's brief is notably short on citations to cases where this Court deferred to congressional findings while applying true, heightened scrutiny to violations of fundamental substantive rights. Instead, Petitioner cites to one case involving military policy, where special deference has always been accorded Congress,[9] cases involving procedural due process claims,[10] a plurality opinion in an Establishment Clause case where deference was clearly not necessary to the result,[11] and one case dating from 1926,

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[9] *See Rostker v. Goldberg*, 453 U.S. 57, 64-65 (1981).

[10] *See Jones v. United States*, 463 U.S. 354, 364 (1983); *Walters v. Nat'l Ass'n of Radiation Survivors*, 473 U.S. 305, 330 n.12 (1985).

[11] *See Bd. of Educ. v. Mergens*, 496 U.S. 226, 250 (1990).

which involved review for reasonableness of express congressional power and which involved neither express congressional findings of fact nor fundamental constitutional rights.[12] Petitioner fails to cite a single case in which this Court categorically deferred to legislative findings of fact that determine the scope and meaning of a fundamental constitutional right. Further, while it may be true that this Court does not lightly second-guess legislative judgments, that is not to say that all such judgments, including those resolving medical and scientific uncertainties, are immune from independent judicial review or that they must be upheld on a mere showing of reasonableness.

III. UNDER HEIGHTENED SCRUTINY, QUESTIONS OF FACT AND MIXED QUESTIONS OF FACT AND LAW ARE REVIEWED *INDEPENDENTLY*

When measuring the constitutionality of legislation, this Court consistently substitutes its own factual determinations for those made legislatively. While the Court is not always explicit when it second-guesses a legislature's factual basis for its lawmaking, holdings that rest upon a less than deferential treatment of legislatively found facts cut a broad swath across constitutional law. When basic rights are at issue, courts must not defer to legislative fact-finding, but rather must engage in a searching and *independent* form of review. Our proposed standard of independent review differs from the traditional *de novo* standard of review. Courts owe due respect to legislative fact-finding and legislatures should be encouraged to collect data, hold hearings and otherwise discover the empirical consequences of legislation that impacts basic rights. Courts should duly consider this research in their constitutional deliberations. This approach

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[12] *See Lambert v. Yellowley*, 272 U.S. 581, 589, 594-95 (1926).

is more consistent with a properly formulated standard of independent review than what a true *de novo* test would mandate.

Indeed, this Court has repeatedly extolled Congress's fact-finding capabilities, and of legislatures more generally. This compliment to Congress's empirical acumen is a function of both respect for a coordinate branch of government and recognition that legislators typically have greater resources at their disposal than do judges. Legislators can sponsor research, hold hearings, and call expert witnesses. They also have great flexibility to refine their research questions and redefine the scope, direction and size of any inquiry. As Justice Souter observed in *Washington v. Glucksberg*, 521 U.S. 702, 788 (1997), legislatures "have more flexible mechanisms for fact-finding than the Judiciary," as well as "the power to experiment, moving forward and pulling back as facts emerge within their own jurisdictions." Courts, by comparison, are more limited because they cannot initiate or fund research and the factual questions that come before them are fairly well-defined by the parties or controlling law. Judges, unlike legislators, rarely question witnesses and usually do not specify which experts are called to testify. These institutional differences have led this Court to express its preference for congressional fact-finding and to recognize its own limited capacity to match the resources legislatures bring to fact-based inquiries. *See* DAVID L. FAIGMAN, LABORATORY OF JUSTICE: THE SUPREME COURT'S 200-YEAR STRUGGLE TO INTEGRATE SCIENCE AND THE LAW (2004).

While the power of Congress to find facts must be duly recognized, this does not necessarily affect the standard of review courts bring to congressional fact-finding. Courts too are fact finders. Congress may excel in defining and financing research, but courts excel at hearing controverted evidence and reaching a decision free of partisan influence. The federal courts, insulated from the shifting political tides,

are able to evaluate the evidence in a systematic and careful fashion. District courts hear the evidence and accordingly must evaluate the credibility of witnesses and the reliability and validity of proffered expert testimony. Moreover, there is rarely a shortage of proffered qualified expert opinion particularly, where as here, factual questions turn largely on disputed medical issues and expert evidence regarding medical practice and professional opinion. While the judiciary may not be as well designed institutionally as Congress to *gather* these data, courts are especially well designed to *evaluate* them.[13] District courts are well complemented in this process by appellate courts, which have access to both the trial record and interested third-party *amicus* briefs.

As the cases at bar well illustrate, courts have the wherewithal to make independent judgments regarding the factual propositions that imbue constitutional cases. This Court has the full legislative records before it, as well as the benefit of extensive expert testimony from the trial courts below. Moreover, the expert opinions were initially admitted under the critical auspices of Federal Rule of Evidence 702 and *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. 579 (1993), and further subjected to the rigors of adversarial testing. Finally, the legislative records at issue here are buttressed by a bounty of *amicus* briefs regarding the factual issues at hand. Simply on the basis of institutional competence, therefore, courts are well positioned to make independent judgments regarding disputed constitutional facts.

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[13] Indeed, there are reasons to doubt whether Congress's institutional capacity for fact gathering is matched by its institutional incentives for accurate fact-finding. *See* Neal Devins, *Constitutional Factfinding and the Scope of Judicial Review* in CONGRESS AND THE CONSTITUTION (Neal Devins and Keith E. Whittington, eds. 2005).

Adopting a nondeferential standard of review in constitutional cases involving fundamental liberties will not dissuade legislatures from compiling a full record. Indeed, given the need in these cases to meet a rigorous standard of review, legislatures can be expected to do more to ensure a full factual record. Congress should continue to gather facts, hold hearings, sponsor research, and otherwise inform itself and future interested parties of the empirical reasons for its action. Courts should give due consideration to the factual findings gathered by Congress. But courts cannot be overly deferential to such fact-finding, lest they abdicate their responsibility under the Constitution.

CONCLUSION

When legislative enactments burden fundamental constitutional rights, and therefore trigger heightened review, a reviewing court must engage in an independent, searching review of *all* the issues raised, including issues of legislative and constitutional fact. This Court has consistently engaged in such independent review in cases involving fundamental rights in the modern era, and has also recognized that independent review is essential if the judiciary is to retain its preeminent role in interpreting and enforcing constitutional restrictions on legislative power. Reviewing courts can and should take account of, and give due respect to, legislative findings relevant to the factual questions at issue; but by no means does such respect require the form of deference Petitioner advocates here.

Respectfully submitted,

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APPENDIX

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No. 05-1382

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IN THE

Supreme Court of the United States

ALBERTO R. GONZALES, Attorney General,

Petitioner,

v.

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., *et al.*,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF OF FAITH AND ACTION, INSTITUTE IN BASIC LIFE PRINCIPLES, INTERNATIONAL REAPERS FOUNDATION, THE NATIONAL CLERGY COUNCIL AND ILLINOIS STATE SENATOR DAVID SYVERSON AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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INTEREST OF AMICI[1]

Faith and Action, Institute in Basic Life Principles, International Reapers Foundation, the National Clergy Council and Illinois State Senator David Syverson join together in this amicus brief in the defense of the sanctity of life and in particular to protect the constitutionality of the federal Partial Birth Abortion Ban Act (PBA Act).

SUMMARY OF ARGUMENT

This Ninth Circuit case and the Eighth circuit case of *Gonzalez v. Carhart*, et l., 05-380 found the PBA Act to be unconstitutional. Amici join hands with petitioner and other Amici in asserting that the PBA Act which prohibits deliberately killing a live baby "outside the body of the mother," 18 U.S.C. § 1531(b)(1)(A), is constitutional. Amici incorporates by reference the statement of facts, principles and argument both in Petitioner's brief and that of other amici that the PBA Act should be sustained as constitutional. This brief does not restate facts or argument previously made.

The core of amici's argument is that this contentious and divisive issue of the barbaric act of abortion must be resolved as a matter of the foundational law which is contained in the Declaration of Independence. The United States Constitution is the document required by the Declaration of Independence to implement and protect the rights established in the Declaration.

The antithesis of that invites manufactured and divisive constitutional interpretations which are often driven by political or personal predilection. A ruling, without a legal foundation of absolutes, and based purely upon fluctuating human reasoning and "wisdom" expands ever wider the

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1. Copies of consents from the parties are being lodged herewith. Counsel for any party did not author this brief in whole or in part. No person or entity except amici or its counsel made any monetary contribution to the preparation or submission of this brief.

religion of "state dictated morals," or "religion" if you will, which our Constitution was designed to prevent.

INTRODUCTION

Failure to base decisions on a firm legal foundation has resulted in opinions dealing with moral issues which are sharply divided. Abortion originated with the split decision in *Roe v. Wade*, 410 U.S. 113, (1973).

The resulting cultural and political division spawned by this issue in the interim has intensified to the point it mirrors the division which existed in this country on the slavery issue in the 1850s. God's law of equality in the Declaration was being violated by the people. That violation was approved and abetted by the United State Supreme Court in the infamous ruling in *Dred Scott v. Sandford*, 60 U.S. (19 Howell.) 393 (1857), which holding was derived solely from human reasoning and not based on any constitutional law. The explosive consequences for that violation of law took this nation into the civil war, the bloodiest and most costly conflict in our history to date, and the stain is still with us.

The same conditions and symptoms are present in our current day society. The question is what is the law that is being violated? The national problem on abortion and other moral issues has been exacerbated by the judiciary's failure over the last sixty years to recognize and address the root cause which now clamors for attention and solution in our culture, the Congress, and the courts of our land. Unless a rational and objective examination is made to identify the root cause and successfully excise it, there are tragic consequences equal to that of the civil war in store for this nation, and its people. That is not an idle prophecy but as this brief will attempt to illustrate, a readily foreseeable and already evident consequence.

Unless one plays the part of one of the classic three monkeys, "see no evil, hear no evil, speak no evil," it is

patently evident that American culture is changing rapidly in the area of social, moral, and legal constraints which only recently were in place and are now breached regularly and with impunity. It is well known, for example, the federal government provides funds for the display of homoerotic photographs that instead of using tax dollars as is currently the case would in the past have attracted the attention of the police.

The evidence demonstrates beyond a reasonable doubt that we are politicizing our culture with resulting damage to institutions and disciplines that once had standards of integrity unrelated to political results. Moral relativism is rampant and contrary to the philosophy of government in our founding documents.

Failure to evaluate and properly address the root cause rather than deal in isolation with the surface problem presented by this case will hazard the continued freedom of the people of this nation and its very survival. The decision in this case must be based upon law not human reasoning absent a legal foundation. Such decisions ultimately result in tyranny.

The question has been raised whether or not, other than *stare decisis*, abortion enjoys any "constitutional protection." It is obvious that the justices wrestle to find a valid answer to the issue aside from their own individual predilections. A window of opportunity lies before this court to determine and unanimously resolve the root issue as a matter of constitutional law and put the confronting problem back in the lap of the people of this republic where it belongs. That is what this brief is about.

ARGUMENT

Justice Scalia's comments in *Stenberg v. Carhart*, 530 U.S. 914, 953 (2000) which appear to echo the absence of a foundation and the need for constitutional law on which to render an opinion stated:

> It (Casey) seemed to me, quite to the contrary, the 'rule fanned into life an issue that has inflamed our national politics in general, and has obscured with its smoke the selection of Justices to this Court in particular, ever since;' and that, 'by keeping us in the abortion-umpiring business . . . O'Connor's concurrence that the issue of abortion is one of the most contentious and controversial in contemporary American society persists in the belief that this court, armed with neither constitutional text nor excepted tradition, can resolve that contention in controversy rather than be consumed by it.

While dealing with a First Amendment issue, Justice O'Connor fretted with the same problem of a lack of constitutional absolute in building a decision in *Wallace v. Jafree*, 472 U.S. 38 (1985) when she observed:

> . . . we must strive to do more than erect a constitutional signpost (internal citation) to be followed in any particular case in which our predilections may dictate. Instead our goal should be to frame a *principle for constitutional adjudication* that is not only grounded in the history and language of the First Amendment but one that is also *capable of consistent application* to the relevant problems. (Emphasis supplied)

Justice Kennedy likewise reflected his concern over a lack of constitutional absolute upon which to predicate a decision in *Allegheny v. ACLU*, 492 U.S. 573 (1989):

> Either the endorsement test must invalidate scores of traditional practices recognizing the place religion holds in our culture, or it must be twisted and stretched to avoid inconsistency with practices we know to have been permitted in the past, while condemning similar practices with no greater endorsement affect simply by reason of their lack of historical antecedent. (FN 10)Neither result is acceptable.

Much as in the horrible mistreatment of slaves who were legally relegated to the category of "non-persons" alla *Dred Scott*, the record in the court below describes in cold medical terms procedures followed in aborting a baby in the first and second trimester, let alone in the third term, and narrates the horror with which we are dealing.

Reaction to the horror described in the record is captured in Justice Scalia's dissent in *Stenberg* at 956:

> I am optimistic enough to believe that one day *Steinberg v. Carhart* will be assigned its rightful place in the history of this court's jurisprudence beside *Korematsu* and *Dred Scott.* The method of killing a human child-one cannot even accurately say an entirely unborn human child-proscribed by this statute is so horrible that the most clinical description of it evokes a shudder of revulsion . . . the notion that the Constitution of the United States, designed among other things, 'to establish Justice, insure domestic Tranquility, . . . and secure the Blessings of Liberty to ourselves and our posterity,' prohibits the states from simply banning this visibly brutal means of eliminating our half borne posterity is quite simply observed.

Justice Kennedy, joined by Chief Justice Rehnquist, likewise reacted in their dissent to the horror testified to by the abortionist, Dr. Carhart, as contained in the record at Stenberg at 959:

> Dr. Carhart has observed fetal heartbeat via ultrasound with 'extensive parts of the fetus removed,' testified that mere dismemberment of a limb does not always cause death because he knows of a physician who removed the arm of a fetus only to have the fetus go on, to be born 'as a living child with one arm.[2] (Reference to the record omitted)

Would there be any mystery as to what decision the United States Supreme Court of 1790 would render on those facts; or even the court in *Roe v. Wade*, 410 U.S. 113, (1973).

The Supreme Court's divided opinion in *Roe v. Wade*, at 116,153 *supra*, held the Texas and Georgia statutes criminalizing abortion unconstitutional while acknowledging that those statutes, "typical of those that have been in effect in many states for approximately a century," were unconstitutional. Recognizing their awareness "of the sensitive and emotional nature of the abortion controversy," the court justified its decision stating at 153,154:

> Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity, or additional offspring, may force upon the wall in a distrustful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem

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2. The child is still living with only one arm at about the age of six, the result of a determination that "a woman's right to choose" was superior.

> of bringing a child into a family already unable, psychologically and otherwise, to care for it. In other cases, as in this one, the additional difficulties and continuing stigma of unwed motherhood may be involved. All these are factors the woman and her responsible physician necessarily will consider in consultation . . . As noted above, a State may properly assert important interests in safeguarding health, in maintaining medical standards, and in protecting potential life. At some point in pregnancy, these respective interests become sufficiently compelling to sustain regulation of the factors that govern the abortion decision.

The majority in *Stenberg* (*ibid* p.920, 921) further justify the procedure in third term abortion on the grounds that American women, absent a ruling permitting abortion, even to the extent of exterminating a live birth, would be "condemned to live lives that lack dignity." Reciting the court's judgment that "*constitutional law*" must govern, the court affirms it has been determined and redetermined "in the course of a generation" that "the Constitution offers basic protection to the woman's right to choose." (Emphasis supplied)

To the contrary, that "generation" of "*stare decisis*" is not law but simple precedent. Only Congress can make law. Federal Constitution Art. I.

It is maintained that God's absolute law was adopted as the "rule of law" in our Declaration of Independence and as such does preclude abortion . . . When that Divine law is aborted, and one is left to human predilections based upon one's own reasoning and evaluation, the ultimate aftermath over a period of time where such rulings are based upon tyrannical state control results in tragic consequences.

The founding decision of this escalating horror of abortion *Roe v. Wade*, 410 US 113, 153, (1973) based upon some slip and slide human reasoning, passed off as constitutional logic, stated:

> The appellee and certain amici argue that the fetus is a person within the language and meaning of the 14th amendment. In support of this, they outline at length and in detail the well-known facts of fetal development. If this suggestion of personhood is established, the appellant's case, of course, collapses, for the fetus' right to life is guaranteed specifically by the amendment. The appellee conceded as much on reargument.

A review of decisions in this area over the last 60 years demonstrates that since the unsupported decision of Roe, even *stare decisis* has not been followed; rather the latitude for permitted abortions has escalated to the point that we are now arguing about whether it is constitutionally justifiable to kill a living person. As a matter of fact if this act is stricken, there will be no statutory restrictions governing abortion.

This Court must not blind itself to the fact that the issues in this case are wed to other constitutional decisions involving moral issues determined by this court. Those controversial decisions stem from the same root cause, a violation of absolutes, and surrender to the moral relativism of our day.

FOUNDING DOCUMENTS-ORGANIC LAW

The documents on which the conclusion is reached that the federal Constitution is legally founded upon are incorporated into the Declaration of Independence and thus constitutes our Rule of Law are set forth in pertinent part in the attached appendix in the order adopted as a basis for our discussion: Appendix A, the Declaration of Independence; Appendix B, Articles of Confederation; Appendix C,

Northwest Ordinance of 1787; Appendix D, United States Constitution. These documents have been recognized in The United States Code as the organic documents of the United States of America.

THE FOUNDATION OF THE CONSTITUTION IS THE DECLARATION OF INDEPENDENCE

The simplicity of our founding documents can be reduced in substance to one sentence: There is a Creator God, and our rights and foundational law come from Him. The purpose of any civil government is to protect and defend those God given rights.

Stare decisis is not law, only precedent. Paraphrasing Sir William Blackstone from his *Commentaries on the Law of England*[3] he states that precedent is the result of the same fact pattern appearing in litigation which had been previously determined and is to be given due weight in reaching a decision. Two reasons are given: the first that it promotes stability and a reasonable expectation in the community of how such a fact pattern will be adjudicated; secondly it requires a judge to be mindful that he is to decide cases "not according to his own private judgment, but according to the known laws and customs of the land." Judges are not to "pronounce a new law but to maintain and expound the old one." (*Ibid*) Blackstone was perhaps accepted as the leading legal scholar at that time. Thomas Jefferson once said that American lawyers used Blackstone with the same dedication and reverence that Muslims used the Koran.[4]

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3. Commentaries on the Law of England Volume I, William Blackstone. University of Chicago press facsimile of the first addition, p. 69.

4. *Writings of Thomas Jefferson*, Albert Bergh, editor-Washington DC: The Thomas Jefferson Memorial Association, 1904, Volume 12, Page 392, to Governor John Tyler on May 26, 1810.

The structure of any government is built upon some foundation of a worldview whether expressed in writing or not.

A friend of mine visited the Ohio State University on a speaking engagement and was taken on a tour of the campus. The guide brought him to the newest building on the campus at that time, the Wexnir Center for the Arts which boasted "post modernist" architectural design. "What is 'post modern' design?" he asked the guide.

The guide rather proudly explained that there were stairways that went no place, pillars that do not support anything, just randomly put together. "The architect's reason," the guide stated, "is that since life is capricious, why should our buildings have any meaning or purpose when life itself has no meaning or purpose?"

From the group of people standing there my friend asked amidst laughter: "Did he do the same with the foundation? Did the foundation have any purpose or design or certain boundaries or certain laws that it had to keep?" We can fool each other at the infrastructure level, but we cannot fool with reality on the foundational level because the foundation will show us whether it can withstand the various elements that attack the foundation.

Some historical documents are listed that develop the irrefutable conclusion that the Declaration of Independence is in fact the United States foundational law and contains our philosophy of government: (1) Declaration and resolution of the first Continental Congress, October 14, 1774; (2) Resolution for independence adopted by the Continental Congress July 2, 1776; (3) Declaration of Independence adopted by the Continental Congress July 4, 1776; (4) Articles of Confederation March 1, 1781; (5) Northwest Ordinance July 13, 1787; (6) Constitution of the United States September 17, 1787.

In a democracy the majority rules by popular vote. In a Republican form of government it is by "rule of law," through duly elected representatives. The founders made clear the reason for the Republic and warned against the disastrous consequences of a democracy.

The passage of the "intolerable acts" in 1774 brought widespread demands for a Congress of all the American colonies. Representatives were sent to a Continental Congress which adopted a resolution on October 14, 1774 that the colonies were entitled to life, liberty, and property, which they had never ceded to any sovereign power. A resolution for independence, a legal document severing any and all legal connection between the Colonies, on the one hand, and Great Britain on the other hand, was adopted by the Continental Congress on July 2, 1776.

Two days later on July 4, 1776 "the Representatives of the United States of America, in General Congress assembled appealing to the Supreme Judge of the World for the rectitude of our intentions . . ." adopted that legal document, the Declaration of Independence.

This official legal action taken by the Congress established a new nation based upon the recognition of the existence of the "Laws of Nature and of Nature's God," [the rule of law], the existence of the Creator, the endowment of all men [all people] with unalienable rights given by the Creator. That legal document contained the precise and binding clause: "That to secure these rights, governments are instituted among men, deriving their just powers from the consent of the governed."

Thus was established the legal philosophy of government of the now established "new nation, the United States of America," which in its founding legal document recognizing the Creator who actually created, not just political hyperbole, all men equal. They were each endowed with unalienable rights that came from the Creator, and man was to submit to

be governed by the immutable laws, not by the fluctuating human reasoning of man. A government was ordained to be built upon that legal platform for the purpose of securing those rights which came from God, and was to be Republican in form.

It is important to remember in the context of this, that the Constitution *did not* create the new nation. It was the document that was to simply govern the new nation according to the requirements established in the Declaration The carefully chosen words in the preamble of the Constitution of the United States committed the purpose of the Constitution to "secure the blessings of liberty to ourselves and our posterity. . . ." The precise phrase, "blessings of liberty" recognized the legal requirement of the Declaration that these "rights of liberty" came from God, not man, and that the formation of this Constitution based upon that legal requirement was to "secure" those rights.

The terms in the Declaration, "deriving their just powers from the consent of the governed," meant that the governing document would construct a Republican form of government to comply with the "contractual" provisions of the Declaration.

The third sentence in the second paragraph of the Declaration is of great legal significance. This new nation, the United States of America, had laid its legal foundation on the philosophy of government which recognized God, His gift of unalienable rights, and that all men were created equal. That constituted the legal philosophy of government, and the legal document yet to be drawn would constitute a Republican form of government to preserve those rights.

If the people determined that "form of government became destructive of those ends," they could institute a new government by "laying a foundation. . . ." consistent with the exegesis of the Declaration. The term "government" is thus modified by the legal requirement of a foundation. This

particular provision further recognized that the Declaration contained the foundational law of this new nation, the United States of America.

Up until July 4, 1776, the soldiers had been fighting for the defense of the "Colonies." The Declaration declared they were now fighting for the United States of America. At General Washington's command, the Declaration was read aloud to the troops and it was now proudly proclaimed as a war for an independent United States of America. A new nation, a new entity had been created and the Declaration set forth the Form of Government for that new nation.

Representatives of the 13 "States" then worked on a "contract document" which would create a coherent means of cooperation between the "States." The Articles of Confederation were thus created by "delegates of the United States of America" "in the year of our Lord one thousand seven hundred seventy seven, and in the Second Year of the Independence of America." They were ratified at the instance of the "Great *Governor* of the World" the "ninth day of July the year of our Lord one thousand seven hundred seventy eight and in the third year of the Independence of America. (Emphasis supplied)

Yet another legal link with the Declaration was forged by the adoption of the Northwest Ordinance in 1787 concerning creating a territory which would thereafter seek to become a state. To become a territory of the United States, its government must comply with the Northwest Ordinance—adopted July 13, 1787 by the United States in Congress assembled—Article Third, providing "religion, morality, and knowledge, being necessary to good government and the happiness of mankind, schools and the means of education shall forever be encouraged."[5] The Ordinance also contains an introductory legal statement, "the fundamental principles of civil and religious liberty, which formed the basis

5. *See Meyer v. United States*, 272 U.S. 52, 174-175 (1926).

whereupon these republics, their laws and constitutions are erected . . . (Art. 5) Provided, the Constitution and government so to be formed *shall be Republican* . . ." (Emphasis supplied). Notice the requirement of a "foundation" on which the Constitution was to be constructed. The imprint of the Declaration is clearly evident in the wording of that ordinance.

The Constitution of the United States was thereafter adopted "the 17th day of September in the year of our Lord one thousand seven hundred and eighty seven, and of the independence of the United States of America the 12th. This Constitution was to replace the inept Articles of Confederation and form a "more perfect union." The States then submitted to the terms of the new constitution which now became the governing document required by the Declaration.

Choosing the precise words to be utilized in documents to carry a particular message in those days was an art. Consequently the words chosen in the Preamble of the Constitution, "We the people of the United States . . . do ordain and establish this Constitution *for* the United States of America." The word "for" was chosen specifically because of its legal significance to indicate that this Constitution was the Republican form of government determined by the Declaration to "secure these rights," *i.e.* the rights set out in the Declaration.

Other phrases in the Constitution were selectively used, it is contended, to tie the legal documents of the past into the Constitution. For example In Article VI, the little noticed phrase, ". . . All debts contracted and engagements entered into before the adoption of this Constitution shall be as valid against the United States under the Constitution as under the Confederation . . ." in accord with the adoption of the Declaration constituted such a valid "engagement." Article IV provided for full faith and credit to "judicial proceedings,"

in every state which would include the recorded judicial record of approving the Declaration, as well as guaranteeing a Republican form of government which was created in the Declaration, and was binding on each.

The original States endorsed the Declaration and every State since has been required to provide a government that is ". . . republican in form and in conformity with the Constitution of the United States and the *principles of the Declaration of Independence* . . ." As late as August 21, 1959, when the State of Hawaii was admitted to the United States, Pub. L. No. 86-3, 73 Stat. 4 (1959) found the Constitution of Hawaii to be ". . . republican in form and in conformity with the Constitution of United States and the principles of the Declaration of Independence . . ." (Emphasis supplied)

Illustrations of enabling acts of territories admitted as States referencing the Declaration state: "[T]he Constitution, shall be Republican, and not repugnant to the Constitution and the principles of the Declaration of Independence." *See* Colorado, [6] Nevada, [7] Nebraska,[8] and Oklahoma.[9]

Justice Douglas in *McGowan v. State of Maryland*, 366 U.S. 420, 81 S. Ct. 1218 (1961).] captured that historical fact in these words:

> The institutions of our society are founded on the belief *that there is an authority higher than the*

6. *The Statutes at Large, Treaties, and Proclamations of the United States Of America*, George P. Sanger, editor (Boston: Little, Brown, & Co., 1866), Vol. XIII, p.33, 38 Congress, session 1, chapter 37, section 4, Colorado enabling act of March 21, 1864

7. *Id.* At Vol. XIII, p.31, Nevada's enabling act of March 21, 1864

8. *Id.* At Vol. XIII, p.48, chapter 59, section 4, Nebraska's enabling act of April 19, 1864

9. The Statutes at Large of the United States Of America (Washington: Government Printing Office, 1907), Vol.XXXIV, Part 1, p.269, 59th Congress, session 1, chapter 3335, section 3, Oklahoma's enabling act of June 16, 1906.

> *authority of the State; that there is a moral law which the State is powerless to alter*; that the individual possesses rights, conferred *by the Creator*, and which government must respect. The Declaration stated the now familiar theme: 'We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable rights, that among these are life, liberty, and the pursuit of happiness.' *And the body of the Constitution as well as the Bill of Rights enshrined those principles*. (Emphasis added)

Former President John Quincy Adams at the Jubilee of the Constitution on April 30, 1839, the 50th anniversary of the inauguration of President Washington stated:

> This act [the Constitution] was the compliment to the Declaration of Independence; founded upon the same principles, carrying them out into practical execution, and formulating with it, one entire system of government . . . the Declaration and Constitution are parts of one consistent whole, founded upon one and the same theory of government, then new, not as a theory, for it had been working itself into the mind of man for many ages, and been especially expounded in the writings of Locke, but had never been adopted by a great nation in practice.[10]

See also the remarks of John Quincy Adams in his famous oration, "The Jubilee of the Constitution;"[11]

Also see the signatories of the Founders who dated their government acts from the year of the Declaration rather

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10. *America's Rule of Law* by Robert C. Cannada; published, National Lawyers Association Foundation (2001).

11. John Quincy Adams, *The Jubilee of the Constitution* (New York: Samuel Coleman, 1839), p. 54.

than the Constitution, for example: President George Washington,[12] President John Adams, [13] President Thomas Jefferson, [14] President James Madison,[15] President James Monroe,[16] President John Quincy Adams,[17] President Andrew Jackson.[18]

Alexander Hamilton concurred saying the Constitution is nothing but the body and letter of the Declaration which is its thought and spirit.[19] He added that the law was dictated by God Himself and that no human law was of any validity contrary to God's law.[20]

In a turn-of-the-century case the court held: "The latter [Constitution] is but a body and the letter of which the former [Declaration of Independence] is the thought and the spirit, and it is always safe to read the letter of the Constitution in the Spirit of the Declaration of Independence." *Gulf, Colorado and Santa Fe Railroad Co. v. Ellis*, 165 U.S. 150, 160 (1897).

November 19, 1863, President Lincoln in his Gettysburg Address officially recognized the Declaration of Independence as the beginning of this nation. Its Philosophy of Government was the reason for the bloody civil war because the government

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12. James D. Richardson, a *Compilation of the Messages and Papers of the Presidents, 1789-1897* (Authority of Congress, 1899), Vol. I P. 80, August 14, 1790.

13. Richardson, Vol. I, p. 249, July 22, 1797.

14. Richardson, Vol. I, p. 357, July 16, 1803.

15. Richardson, Valhi, p. 473, August 9, 1809.

16. Richardson, Vol.II, p. 36, April 28, 1818.

17. Richardson, Vol.II, p. 376, March 17, 1827.

18. Richardson, Vol.II, p. 440, May 11, 1829.

19. *The Federalist*, p. 275, Federalist # 49 by Alexander Hamilton.

20. Alexander Hamilton, *The Papers of Alexander Hamilton*, Harold C. Syrett, Editor (New York: Columbus University Press, 1961), Vol. I , p. 87, February 23, 1775.

of the United States, which had been formed to protect the rights declared in the Declaration, was standing by that obligation even to the point it was committing its citizens to battle and death. After reciting the provisions of the Declaration, the President stated with reference to the Declaration:

> . . . They erected a beacon to guide their children, and their children's children, [T]hey established these great self-evident truths that . . . their posterity might look up again to the Declaration of Independence and take courage to renew that battle which their fathers began, *so that truth and justice and mercy and all the humane and Christian virtues might not be extinguished from the land. . . .*[21] (Emphasis supplied)

THE DESTRUCTIVE ALTERNATIVE IN DISCLAIMING THE DECLARATION AS OUR GOVERNING DOCUMENT

The Founding Fathers set out in the Declaration of Independence absolute truths for the foundation of our government. If the Declaration of Independence has no legal significance, then the "Rule of Law" to which our government is subject would be found to be based upon human reasoning rather than that which is found in the Declaration. An ostensible "Rule of Law" predicated only upon "human reasoning" does not qualify as a rule of law. It is only a rule set by human reasoning. The "Rule of Law" established in the Declaration was predicated upon absolute truth from the Divine Mind, which does not fluctuate or change. On the other hand, man's rules are constantly adjusting according to the foibles of man's thinking, even to the point of asserting there are no absolutes and engaging in circumstantial ethics.

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21. Abraham Lincoln, The Works of Abraham Lincoln: Speeches and Debates, John H. Clifford, Editor (New York: the University Society Inc., 1908), Vol. III, pp. 126-127, August 17, 1858.

Rules that are generated by man do not recognize the absolute rules of God, and constitute the establishment of an atheistic philosophy of government, specifically contrary to that which was established in the Declaration. We are not talking about religion but the source of absolute truth as a governing basis. Once the Constitution is set adrift from the Declaration it permits the government, and particularly the courts, to proclaim "truths" that are flexible and changeable depending upon the predilection of the one making the rule.

History discloses during our own lifetime what the ultimate conclusion of that can be. The old adage that, "it can't happen here," is simply passé; we are already seeing the consequences of arbitrary rulings contrary to the standards of God which are laid down in our Declaration. As a matter of fact, talking about God is put down in today's culture as some sort of "mystical or far right" thinking. To the contrary, those that decry the reality of God are living in an imaginary world of their own making without any sense of an eternal destination. The rules of life apply also to a nation: (1) origin; (2) purpose for existing or living; (3) a foundation of moral values; (4) an ultimate destination. The alternative is an atheistic, humanistic form of government which cannot provide a foundation of "unalienable rights," and which exists without any sense of real stability, a society that creates fear in an individual and a nation.

Fifty years ago, abortion was murder and the doctor was charged for that criminal act; sodomy was a criminal act; pornography was a criminal offense; fornication was at least a misdemeanor; adultery was a criminal offense; living together without the sanction of marriage was a criminal offense; inappropriate dress or indecent exposure was at least a misdemeanor; and there was a clear demarcation between that which was considered right or wrong including the kind of language one used in public.

In today's culture we have migrated to the point that all of the foregoing is acceptable under constitutional interpretations that to hold otherwise would rob the individual of his rights or his unbridled liberty.[22] The result of that journey out of the sunlight and into the shadows is illustrated by this case in which there are two sides arguing to the court which must decide whether or not it is constitutionally appropriate to kill a living child in the process of birth.

Finding that this killing is wrong and unconstitutional on any other basis than that it violates the God-made rules of the Declaration, only dictates the problem will revisit this court in one way or another and keep this court, as Justice Scalia contends, in the "abortion umpiring business." The problem is immorality does not stand still, it only propagates greater evil. Around the corner are the moral issues of euthanasia, legal suicide, medical experimentation, "right to die" laws; and other moral issues camouflaged under the guise of "rights." The rhetoric justifying *Stenberg* could ultimately justify killing the elderly, crippled, mentally retarded, etc.

A judiciary which divorces itself from the binding absolutes contained in the Declaration, and its moral absolutes would be set adrift on a sea of unpredictability. It would operate for a period of time under the illusion of applying constitutional principles until the horrendous consequences were overwhelming. Gone would be our cherished "unalienable rights." Human rights would be totally dependent upon the State; which acronym, incidentally, has been referred to time and time again in the case law as the arbiter of our moral rights, rather than God's absolute standard of truth. Our immediate history is aflame with the potential product of "State control without God's moral conscience."

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22. Consider the shadows we are now walking in and determine realistically where it is taking us. Consider for example the case of *Lawrence v.. Texas*, 539 U.S. 558 (2003) and its aftermath and the fulfilled prophecy of Justice Scalia.

An example of the ultimate destiny of arbitrary state control unhampered by God's moral restraint can be seen in the photographs attached to this brief. (Exhibits 1-3). They demonstrate the residue of moral consequences resulting from a government by the "state" when stripped of all recognition of God and his absolute truths. The particular State government in question denied that we were *Created* by God with unalienable rights, but rather embraced the godless philosophy of evolution as coined by Darwin. It would be well to read the Nuremberg trial record and associate Justice Robert Jackson's comments and statements and review the evidence to renew in our minds the degradation to which state control can take a society. It can be a slow, incremental transition from freedom to slavery.

To the absolute contrary, our Declaration which is the moral foundation of our law, stated we were created beings, not chance accidents. In making that assertion the drafters "appeal to the Supreme Judge of the World for the rectitude of our intentions," which embodies the concept of God's moral law as earlier referred to in the Declaration, with the recognition of coming eternal judgment. For the last sixty years or more, we have been creating an atheistic society by the persistent removal of God from a viable reality in our court system, educational system, and body politic. Not being a litigating body or able to get directly involved in politics, the church has fallen prey to the big business of organizations like the ACLU, Planned Parenthood, and others of the same ilk who have made great capital off of the selfishness of man and his self-centered desires.

The result is that the vacuum has been filled with an atheistic philosophy without any counterbalance from the Word of God. We are educating our young people, for example, with the scientifically unsupported Darwin's theory of evolution as though that represented scientific truth.

The background for that teaching is the "God is dead and we have killed him" philosophy of the German atheist Frederick Nietzsche. If God is dead then the only thing left is human reason. Thus was developed the theory of positive law. Nietzsche reduced everything in life to the will for self-assertion. Since God-given values were dead, it was up to humans to create their own values.

In 1859 Charles Darwin published his book on macro-evolution, "*On the Origin of Species*." Agreeing with Darwin, Karl Marx said, "In our evolutionary concept of the universe, there is absolutely no room for either a Creator or a Ruler."[23] So parroting Darwin's philosophy of evolution and Nietzsche's nihilistic philosophy, we are educating our young people that "Now" is all we have because there is no tomorrow.

Edwards v. Aguillard, 482 U.S. 578, 579 (1987), without reference to the Declaration or its Rule of Law, the Court authorized the teaching of Darwin's philosophy of evolution, but denied the right to teach God as the Creator. Over the vigorous dissent of Justices Rehnquist and Scalia, the court found, "The act impermissibly endorses religion by advancing the religious belief that a supernatural being created humankind." Students were required to be taught a godless religion of humanism against their religious convictions, or be punished.[24]

This Court is made up of justices who are to judge both "law and fact." Your honors are not immune to evidence of what is going on in the public square. The consequences of publicly aborting our philosophy of government are all about

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23. Marx and Engles On Religion, NY:Schocken 1964, page 295.

24. Without reciting chapter and verse, the court cases are filled with people who allege her feelings for having to look at for example the Ten Commandments. A study should be made of the punishment meted out to individuals who refuse to bow the knee to the godless atheism afloat in our society.

us. The statistics available from a number of sources, demonstrate a downward spiral of morals. Since 1963 birth rates among unwed women from 15 to 19 years of age are spiraling upward, as are violent crimes, drug and alcohol use, divorce and broken families, sexually transmitted disease, sexual problems in our schools even in the grade schools, the AIDS problem (which cannot be directly dealt with concerning immoral conduct because of the "rights" of the individual), family instability; single-family households, dropping SAT scores, and the list goes on.

Is it a relevant question to ask whether or not there is a causal connection between the abandonment of God's moral standards contained in the Declaration and the moral breakdown in this nation? Is it a relevant question to ask that when the founders of this nation were confronted with an overwhelming military situation they cried out to a real God for deliverance, or at 9/11? Yet the court prevents prayer in schools, even in many cases, voluntary prayer or even carrying a Bible to school; certainly the display of the Ten Commandments affecting behavior cannot be tolerated

That rule of relativism is not only not working, it is the antithesis of the law of this land as established in our founding documents and we are paying the consequences.

CONCLUSION

The hypothetical child in a third term pregnancy situation is a person. There is no medical doubt about that conclusion. Consequently that child is entitled to the protection of a "person" under both the 14th amendment and under God's *law* contained in the Declaration of Independence. There may be some squeamishness on the part of the Court in light of the media and contemporary thinking of much of today's society in utilizing that legal terminology, but it did not result in squeamishness on the part of those who wrote the Declaration and to which they committed their lives, their fortunes, and their sacred honor.

Our society has wanted to escape from the tether of moral responsibility under God's law, and it is beginning to reap the whirlwind. This does not deal with religious epitaphs but with law that the founders determined in the Declaration was to provide a secure future for its people and progeny.

Just take the 1.29 million abortions in 2002.[25] It would be interesting to calculate how many of those pregnancies could have been prevented if the laws of 50 or 60 years ago were still in force which made it a criminal offense to engage in fornication, adultery, pornography, producing movies and TV promoting immoral sex, sadistic violence, and other conduct in this area in violation of God's moral law.

Counsel advocates this Court is at a crossroads and will determine what road of destiny this nation will take. This is an opportunity on the part of the Court to act in a very judicious and responsible manner and put the problem back in the lap of the people where it belongs and be done with the umpiring business.

The Declaration of Independence is to be the guiding law of moral conduct and responsibility based upon God's moral law and should dictate the basis for decisions out of this Court. It is contended this Court does not have either the right, or the responsibility to amend the philosophy of government translating it into an atheistic, secular and humanistic society aborting its responsibility to the Creator God of our documents.

If that is to be done, this decision should make it clear that if the people want to change the terms of the Declaration and lay a new foundation on which this government is to be built that becomes the people's responsibility, not the Court's.

The PBA Act should be held constitutional for any number of substantial legal and constitutional reasons. This

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25. Finer and Hinshaw estimates of U.S. abortion incident in 2001 and 2002, AGI (2005).

is the opportunity, however, for the Court to create the role of "freedom for the Court," and declare the Declaration of Independence to be the foundational basis for our Constitution as the philosophy of government by which we are to live as a society.

If the philosophy of government of the United States of America is to be changed, discarding the Declaration of Independence, then "people you do it."

Respectfully submitted,

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APPENDIX A — THE DECLARATION OF INDEPENDENCE

When in the course of human events, it becomes necessary for one people to dissolve the political bands which have connected them with another, and to assume among the powers of the earth the separate and equal station to which the laws of nature and of nature's God entitle them, a decent respect to the opinion of mankind requires that they should declare the causes which impelled them to the separation.

We hold these truths to be self evident, that all men are created equal, that they are endowed by their Creator with certain unalienable rights, that among these are life, liberty and the pursuit of happiness. That to secure these rights, governments are instituted among men, deriving their just powers from the consent of the governed. That whenever any form of Government becomes destructive of these ends, it is the right of the people to alter or to abolish it and to institute new Government, laying its foundation's on such principles and organizing its powers in such form as to them shall seem most likely affect their safety and happiness.

We, Therefore, the Representatives of the United States Of America, in General Congress Assembled, appealing to the Supreme Judge of the World for the rectitude of our intentions, do, in the name and by the authority of the good people of these colonies, solemnly publish and declare that these United colonies are, and of right ought to be free and Independent states that they are of dissolved from all allegiance to the British crown . . . and for the support of this Declaration, with a Firm Reliance on the Protection of Providence, We Mutually Pledge to Each Other Our Lives, Our Fortunes, and Our Sacred Honor.

APPENDIX B — ARTICLES OF CONFEDERATION

To All to Whom these Presents shall come, we the undersigned Delegates of the States affixed to our Names send greeting. Whereas the Delegates of the United States of America in Congress assembled did on the 15th day of November in the year of our Lord One Thousand Seven Hundred Seventy seven, and in the Second Year of the Independence of America agreed to certain articles of Confederation and perpetual union between the States.

Art. I. The Stile of this confederacy shall be "United States of America."

Art. XIII. . . . And Whereas it hath pleased the Great Governor of the World to incline the hearts of the legislatures we respectfully represent in Congress, to approve of, and to authorize us to ratify the said articles of Confederation and perpetual union..... done at Philadelphia in the state of Pennsylvania the ninth day of July the year of our Lord one thousand seven hundred seventy-eight and in the third year of the independence of America.

APPENDIX C — THE NORTHWEST ORDINANCE (1787)

And, for extending the fundamental principles of civil and religious liberty, which *form the basis whereupon these republics, their laws and constitutions are erected*; to fix and establish those principles as the basis of all laws, constitutions, A. and governments, which forever hereafter shall be formed in the said territory: to provide also for the establishment of States, and permanent government therein, and for their admission to a share in the federal councils on an equal footing with the original States . . . (emphasis supplied)

Art. 3. Religion, morality, and knowledge, being necessary to good government and the happiness of mankind, schools and the means of education shall forever be encouraged. . . .

Art. 5. . . . Provided, the constitution and government so to be formed shall be *republican*, and in conformity to the principles contained in these articles . . .

APPENDIX D — PREAMBLE TO THE CONSTITUTION OF THE UNITED STATES

We the people of the United States, in order to form a more perfect union, establish Justice, insure domestic tranquility, provide for the common defense, promote the general welfare, and secure the blessings of liberty to ourselves and our posterity, do ordain and establish this Constitution *for* the United States of America.

Federal Constitution Article VI . . . All debts contracted and engagements entered into *before the adoption of this Constitution shall be as valid against the United States under this Constitution as under the Confederation* . . . and all treaties made or which shall be made, under the authority of the United States shall be the supreme law of the land; and the Judges in every State shall be bound thereby, anything in the Constitution or laws of any State to the contrary notwithstanding.

Article IV Section 1. Full faith and credit shall be given in each state to the public acts, records, and *judicial proceedings of every other state.*

Section 4. The United States shall guarantee to every State in this Union *a republican form of government* and shall protect each of them against invasion. . . .

ARTICLE VII DONE in convention by the unanimous consent of the States present the 17th day of September in the year of our Lord one thousand seven hundred and eighty seven, and of the independence of the United States of America the 12th.

(All emphasis supplied)

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Children Used in Medical Experiments

Jewish children, the victims of medical experiments in Auschwitz

Source: Shoah - The Holocaust

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Children Awaiting Execution

A group of children just before they were executed by an Einsatzkommando

Source: Soviet Union, wartime. Central State Archives of Film, Photo and

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"Euthanasia" Victims

Cemetery at Hadamar where victims of "euthanasia" at the Hadamar "euthanasia" killing center were buried. This photograph was taken toward the end of the war. Hadamar, April 1945. [NARA Photo]

Source: U.S. Holocaust Memorial Museum

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Nos. 05-1382 & 05-380

IN THE

Supreme Court of the United States

ALBERTO R. GONZALES, ATTORNEY GENERAL,

Petitioner,

v.

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., ET AL.,

Respondents.

ALBERTO R. GONZALES, ATTORNEY GENERAL,

Petitioner,

v.

LEROY CARHART, M.D., ET AL.,

Respondents.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH AND EIGHTH CIRCUITS

BRIEF OF AMICI CURIAE, 52 MEMBERS OF CONGRESS IN SUPPORT OF PLANNED PARENTHOOD FEDERATION, INC., ET AL., AND MOTION FOR LEAVE TO FILE BRIEF OUT OF TIME IN SUPPORT OF RESPONDENTS LEROY CARHART, M.D., ET AL., IN RELATED CASE NO. 05-380

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MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE* IN SUPPORT OF RESPONDENTS IN RELATED CASE

52 Members of Congress, hereby move for leave to file a brief *amici curiae* in support of Respondents in the related case, *Gonzales v. Carhart*, No. 05-380.

On February 21, 2006, this Court granted *certiorari* in *Gonzales v. Carhart* to review the judgment of the U.S. Court of Appeals for the Eighth Circuit invalidating the Partial-Birth Abortion Ban Act of 2003, Pub. L. No. 108-105, 117 Stat. 1201 ("Act").

Gonzales v. Carhart raises the same constitutional questions, concerns the same Act of Congress, involves the same petitioner, and will be argued on the same day as the instant case. Furthermore, *amici's* legislative perspective and knowledge of the process which resulted in the Act are equally relevant to both cases.

Pursuant to a letter dated September 19, 2006, Petitioner Gonzales has consented to the filing of this brief *amici curiae* in both cases,[1] and will not be prejudiced in any way by the granting of this Motion since Petitioner will have the opportunity to respond to this brief in his Reply Brief.

Accordingly, *amici curiae* request that the Court grant them leave to file a jointly-captioned brief in support of

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[1] All parties have consented to the filing of this brief *amici curiae* in both cases. Copies of the consent letters have been provided to the Court with the brief.

Respondents, and direct the Clerk to accept this brief out-of-time in *Gonzales v. Carhart*, No. 05-380, and to docket the brief in both cases.

Respectfully submitted,

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Partial-Birth Abortion Ban Act of 2003: Hearing before the Subcomm. on the Constitution of the House Judiciary Comm., 108th Cong. (2003) ..... *passim*

MISCELLANEOUS

Albert Hunt, "Politics and People: Daschle Charts Common Ground on Abortion," *Wall Street Journal*, May 22, 1997 9

Frank Rich, "Hypocritic Oath," *N.Y. Times*, May 29, 1997 9

Sprang & Neerhof, "Rationale for Banning Abortions Late in Pregnancy," *JAMA*, August, 26, 1998 11

INTERESTS OF AMICI CURIAE[1]

Amici curiae are members of the United States Congress who share a concern for the continued vitality of protections first established in *Roe v. Wade*, 410 U.S. 113 (1973), which for the past thirty years have secured and defined a woman's constitutional right to decide whether to continue or terminate a pregnancy free from unnecessary governmental interference, and choose, in consultation with her physician, the safest and most appropriate method of effectuating her decision. Amici here seek to focus specifically on the legislative process that resulted in the Partial-Birth Abortion Ban Act of 2003 (the "Federal Abortion Ban" or the "Ban"), Pub. L. 108-105, 117 Stat. 1201 (codified at 18 U.S.C. § 1531). Many of the amici advocated against passage of the Ban in the form it was enacted. Amici share with the Court their legislative perspective and knowledge of a process that was neither rational nor balanced, and deliberate only with respect to its disregard of this Court's decision in *Stenberg v. Carhart*, 530 U.S. 914 (2000), which invalidated a virtually identical ban, lacking a health exception.

While Congress is not foreclosed from legislating in this area, it must adhere to this Court's constitutional guidelines. Those who wish to ban abortion procedures cannot exploit Congress' fact-finding ability to usurp this Court's authority. Nor should they expect deference to ersatz findings that a health exception is not required when there was no new medical evidence before Congress to support this

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[1] Pursuant to Rule 37.6 of the Rules of this Court, amici state that no counsel for a party has authored this brief and that no person or entity, other than amici or their counsel, has made a monetary contribution to the preparation or submission of this brief. Letters of consent have been filed with the Clerk of the Court.

conclusion. Finally, amici wish to protect the legislative process. This Court cannot, and should not, attempt to rescue this statute by imposing a limited injunction when it is evident from the legislative record that the Ban's supporters would rather have no law than a law that contains a health exception.

SUMMARY OF THE ARGUMENT

> *Why are we here? We are here because the Supreme Court defended the indefensible. They defended the indefensible. We have responded to the Supreme Court. I hope the Justices read this record because I am talking to you...*

(Sponsor Sen. Santorum on this Court's decision in *Stenberg v. Carhart*, 149 Cong. Rec. S3484 (Mar. 11, 2003)).

> *If you vote for [the Feinstein Amendment], you basically vote to kill the bill and replace it with nothing...No one who votes for this can say they are for the partial-birth abortion ban, because they are not. They are for eliminating that ban and replacing it with current law, a restatement of Supreme Court law, which is nothing as far as doing anything about this brutal procedure.*

(Sponsor Sen. Santorum on including a proposed health exception in the Federal Abortion Ban, 149 Cong. Rec. S3605-07 (Mar. 12, 2003)).

For three consecutive congressional sessions leading up to this Court's decision in *Stenberg*, supporters of a federal abortion procedure ban sought to pass legislation substantially similar to the Ban at issue here. The first

version, H.R. 1833, was passed by both houses in 1996, but vetoed by President Clinton because it lacked an exception to protect either the life or the health of a woman in contravention of this Court's abortion decisions. *See* 142 Cong. Rec. H3338 (Apr. 15, 1996). The second version, H.R. 1122, the model for the Nebraska ban found unconstitutional in *Stenberg*, failed to allow a health exception as President Clinton requested, and was vetoed for the same reasons. *See* 143 Cong. Rec. H8891 (Oct. 21, 1997). Finally, in June 2000, differing versions of the ban (H.R. 3660 and S. 1692) which each lacked a health exception were passed by their respective chambers, but never sent to conference given this Court's ruling that year in *Stenberg* requiring a health exception. *Stenberg*, 530 U.S. at 936-37; H.R. Rep. No. 108-58, at 13 n. 68 (2003).

With no new evidence before it, and concluding only that *Stenberg* was based on a "weak record"[2] and "very questionable findings,"[3] Congress enacted the Ban. Unlike the bills that came before it, the Ban incorporates several pages of findings (the "Findings") purporting to explain why Congress decided it could dispense with the health requirement of *Roe*, *Casey*, and *Stenberg*. However, the record on which Congress based its Findings is the same as existed before *Stenberg*, and accordingly, deference to such findings here is inappropriate. Supporters of the Ban did not provide any new evidence disputing the safety of or medical need for the banned procedure that was not already presented during Congress' initial hearings on the subject and before this Court when it concluded that a ban on D&X could endanger women's health. *Stenberg*, 530 U.S. at 938. As such, the Ban is simply a fourth bite of the same rotten apple.

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[2] *See* 149 Cong. Rec. S3384 (Mar. 10, 2003) (statement of Sen. Santorum).

[3] Pub. Law. 108-105, 117 Stat. 1202 at § 2(7).

Throughout the debates, sponsors of the Ban made no secret of the fact that they disagreed with this Court's ruling in *Stenberg* and the constitutional standard it reaffirmed. However, substantial medical authority not only considers D&X to be within the standard of care, but supports the proposition that banning the procedure would endanger women's health. In light of such facts Congress cannot, without some new or compelling shift in the evidence, reverse this Court's ruling by *ipse dixit* "finding" the opposite is true.

By the same token, this Court should not assume the legislature's role when determining the appropriate remedy here. The supporters of the Ban had sufficient constitutional guidance to inform their drafting decisions, and actively chose to flout this Court's rulings. Since it would be impossible for this Court or the lower federal courts on remand to save the statute and remain faithful to legislative intent, the Ban must be facially invalidated.

ARGUMENT

I. The Federal Abortion Ban Is Based On The Same Record As Was Before This Court In *Stenberg*

A. The Pre-*Stenberg* Record

1. 104th Congress. The 104th Congress held three hearings on the subject of "partial-birth abortion." The number of physician-witnesses was quite small,[4] and their testimony was based principally on policy considerations rather than medical authority.[5]

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[4] *See Carhart v. Ashcroft*, 331 F.Supp.2d 805, 822-23 (D. Neb. 2004).

[5] *See Planned Parenthood Federation of America v. Ashcroft*, 320 F.Supp.2d 957, 1014-15, 1017 (2004).

During the first hearing held by the House Judiciary Committee's Subcommittee on the Constitution, Congress heard from four medical witnesses.[6] Only two of these witnesses, Drs. Pamela Smith and J. Courtland Robinson, touched on the potential health implications of the proposed ban.[7] The Senate Judiciary Committee held its own hearing in late 1995 and heard from six medical professionals. Dr. Norig Ellison testified on the impact of anesthesia on the fetus and did not address the safety of or need for the banned procedure.[8] The remaining witnesses were divided as to whether the ban would be detrimental to women's health. The third and final hearing, in March 1996, focused on the impact on the fetus of anesthesia administered to a woman undergoing an abortion,[9] and did not address the safety or necessity of the banned procedure.

Additional written materials were submitted into the record for the hearings, as well as during floor debates. These materials included submissions from physicians who both supported and opposed the ban. In addition, Congress

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[6] *See Partial-Birth Abortion: Hearing before the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 104th Cong., 38-42, 63-65, 67-69, 76-79 (1995) (hereinafter "1995 House Hearing").

[7] Dr. Smith, the Director of Medical Education in the Department of Obstetrics and Gynecology at Mt. Sinai Hospital in Chicago, testified as the president-elect of the American Association of Pro-Life Obstetricians and Gynecologists in support of the proposed ban, while Dr. Robinson, an Associate Professor at John Hopkins University School of Medicine, testified on behalf of the National Abortion Federation in opposition to the ban.

[8] *See The Partial-Birth Abortion Ban Act of 1995: Hearing before the Senate Comm. on the Judiciary*, 104th Cong., 1st Sess. 107 (1995) (hereinafter the "1995 Senate Hearing").

[9] *See Effects of Anesthesia During a Partial-Birth Abortion: Hearing before the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 104th Cong. (1996) (hereinafter the "1996 House Hearing").

received letters from medical center directors and university professors who explained why, in their medical opinion, the ban would be detrimental to women's health and their future reproductive ability.

The record also contains submissions from numerous medical organizations which opposed the legislation. These groups include the American College of Obstetricians and Gynecologists ("ACOG"), the California Medical Association ("CMA"), the American Nurses Association ("ANA"), the American Medical Women's Association ("AMWA"), and the American Public Health Association ("APHA").[10] Only one organization supported the ban: the Physician's Ad Hoc Coalition for Truth ("PHACT"), an organization created solely to advocate for partial-birth abortion legislation, of which Representative Tom Coburn and Hearing witnesses Pamela Smith, Nancy Romer and Curtis Cook were founding members.[11] While some members who supported the bill found it significant that a group of 12 doctors on the American Medical Association's ("AMA") Council on Legislation endorsed the bill, the AMA did not accept the Council's recommendation and decided to remain neutral.[12]

H.R. 1833 passed both chambers, but was vetoed by President Clinton on April 10, 1996.[13]

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[10] *See* 142 Cong. Rec. S11350-51 (Sept. 26, 1996); 141 Cong. Rec. S18190-91 (Dec. 7, 1995); 141 Cong. Rec. S17896 (Dec. 4, 1995); 141 Cong. Rec. H11595 (Nov. 1, 1995).

[11] *See* 142 Cong. Rec. S11370-71, S11388 (Sept. 26, 1996); 142 Cong. Rec. H10637-38 (Sept. 19, 1996).

[12] *See* 141 Cong. Rec. H11786 (Nov. 7, 1995) (statement of Rep. Bryant); 142 Cong. Rec. S11271 (Sept. 25, 1996) (statement of Sen. Nickles); 141 Cong. Rec. H11609 (Nov. 1, 1995) (statement of Rep. Ros-Lehtinen).

[13] 142 Cong. Rec. H3338 (Apr. 15, 1996).

2. 105th Congress. When the veto of H.R. 1833 was sustained, new legislation, H.R. 1122, was introduced in the 105th Congress. The House Subcommittee on the Constitution and the Senate Judiciary Committee held a Joint Hearing in March 1997.[14] Again, the testimony was primarily policy-based, as most of the witnesses were representatives of various public interest groups who advocated for and against the bill.[15] Once again, additional written materials were submitted into the record reflecting the conflicting views of physicians and professional organizations on the subject. For example, Dr. David Grimes, former Chief of the Department of Obstetrics, Gynecology and Reproductive Sciences at the San Francisco General Hospital, described a situation in which several unsuccessful attempts were made to induce labor in a woman suffering from severe preeclampsia, and it became necessary to perform an intact D&E.[16] Dr. Grimes stated that under the circumstances, "an intact D&E was the fastest and safest option available."[17]

The Physicians for Reproductive Choice and Health ("PRCH"), an organization comprised of 2,800 physician members, joined the ACOG, the CMA, the ANA, and the AMWA in opposing the ban.[18] That same term, the AMA

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[14] *See Partial-Birth Abortion: The Truth: Joint Hearing on S. 6 and H.R. 929 Before the Senate Comm. on the Judiciary and the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 105th Cong. (1997) (hereinafter the "1997 Joint Hearing").

[15] Dr. Curtis Cook, Associate Director of Maternal-Fetal Medicine at Butterworth Hospital in Grand Rapids, Michigan, supported the ban and was the only physician to provide live medical testimony concerning the safety or need for the banned procedure. *See* 1997 Joint Hearing at 122.

[16] 143 Cong. Rec. S4521 (May 15, 1997).

[17] *Id.*

[18] *See* 143 Cong. Rec. S4434 (May 14, 1997); 143 Cong. Rec. S4714 (May 20, 1997); 143 Cong. Rec. S4573-74 (May 15, 1997); 143 Cong.

issued a letter in support of the legislation.[19] PHACT also submitted new material in support of the ban.[20] After passage by both chambers, the President vetoed the bill,[21] which veto was again sustained in the fall of 1998.[22]

3. 106th Congress. Both chambers continued to debate different versions of an abortion procedure ban during the 106th Congress.[23] These efforts coincided with the Eighth Circuit's decision invalidating Nebraska's partial-birth abortion ban[24] and this Court's decision to grant certiorari to consider the matter.[25] While no further hearings were held during this legislative term, additional materials were submitted into the record during the floor debates.[26] Importantly, the AMA withdrew its controversial endorsement of the legislation before this Court's decision in *Stenberg*.[27]

Rec. S4549-50 (May 15, 1997); 143 Cong. Rec. S4701 (May 20, 1997); 144 Cong. Rec. S10479 (Sept. 17, 1998).

[19] *See* 143 Cong. Rec. S4698-99 (May 20, 1997).

[20] *See* 143 Cong. Rec. S4549-50 (May 15, 1997).

[21] *See* 143 Cong. Rec. H8891 (Oct. 21, 1997).

[22] *See* 144 Cong. Rec. S10564 (Sept. 18, 1998).

[23] H.R. 3660 (Feb. 15, 2000) and S. 1692 (Oct. 5, 1999).

[24] *Carhart v. Stenberg*, 192 F.3d 1142 (8th Cir. 1999).

[25] *Stenberg v. Carhart*, 528 U.S. 1110 (2000).

[26] These materials consisted primarily of letters that had previously been submitted into the record or letters from medical organizations reaffirming their respective views on the legislation. *See e.g.*, 145 Cong. Rec. S12867-71 (Oct. 20, 1999); 145 Cong. Rec. S12891-92 (Oct. 20, 1999); 145 Cong. Rec. S12982 (Oct. 21, 1999).

[27] The AMA withdrew its support on October 21, 1999, citing Congress' failure to remove the criminal sanctions from the bill. *See Partial-Birth Abortion Ban Act of 2003: Hearing before the Subcomm. on the*

B. The Post-*Stenberg* Record

Following this Court's decision in *Stenberg*, during the 107th Congress, Representative Steve Chabot introduced H.R. 4965, confident that the President-elect would sign an abortion ban into law.[28] Responding to *Stenberg*, the Ban set forth a series of "Findings." Drafted and introduced before

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Constitution of the House Judiciary Comm., 108th Cong., 212 (2003) (hereinafter the "2003 House Hearing"). However, when the AMA announced its endorsement of the ban in 1997, it was immediately criticized for supporting the legislation. *See* Frank Rich, "Hypocritic Oath," *N.Y. Times*, May 29, 1997, § A, at 21 (noting that the same day that the AMA issued its letter supporting the 1997 bill, its executive vice-president sent an eight-page letter to Speaker of the House setting forth the AMA's detailed "wish-list" for Medicare reform); *see also* Albert Hunt, "Politics and People: Daschle Charts Common Ground on Abortion," *The Wall Street Journal*, May 22, 1997, § A, at 15 ("The American Medical Association became steeped in politics this week when it surprisingly endorsed the [partial-birth abortion] ban; there are credible reports that the doctor's lobby secretly struck a deal with GOP leaders over Medicare reimbursement in return for the endorsement"); 143 Cong. Rec. H8661 (Oct. 8, 1997) (statement of Rep. Bentsen – "isn't it surprising that the very day that the AMA announced its switcheroo, its executive vice president, P. John Seward, sent an eight-page letter to Newt Gingrich that lists the AMA requests in the budget negotiations concerning Medicare spending"). Concerned that its change in position appeared to be politically driven, the AMA engaged an independent consulting firm, Booz-Allen & Hamilton, to review its decision-making processes. The consulting firm's final report provided a critical analysis of the process and timeline of events leading up to the AMA's decision to support H.R.1122. *See* 2003 House Hearing at App. at 244-279 (attaching the complete report which concluded that "the combined effect of AMA policies was to allow the most critical, controversial and high-visibility policy issues to be addressed using the least democratic, least researched, and least systematic decision-making process").

[28] *See* 148 Cong. Rec. E1096 (June 19, 2002) (statement of Rep. Chabot – "[w]e now have a President who is equally committed to the sanctity of life, a President who has promised to stand with Congress in its effort to ban this barbaric and dangerous procedure").

Congress had an opportunity to hold any further hearings on the subject,[29] these Findings contradicted the factual findings of the trial court in *Stenberg* and this Court's conclusion that a "statute that altogether bans D&X creates significant health risks." *Stenberg*, 530 U.S. at 938.

The Congressional hearing that followed the drafting of the Findings was politically biased and transparently partisan, calculated to highlight testimony from supporters of the ban. Congress held one hearing during the 107th Congress to consider the medical and legal issues raised by this new legislation, which lasted a mere one hour and thirty-five minutes.[30] At that hearing, two physicians testified in support of the ban. Their testimony did not differ in any material respect from the testimony presented during the 104th and 105th Congresses.[31] Additional materials from medical professionals were submitted into the record. However, the bulk of the documents included in the hearing appendix consisted of hearing testimony and written materials previously submitted during the 104th and 105th Congresses.[32] H.R. 4965 passed the House, but the Senate never considered the legislation.

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[29] *See* H.R. Rep. No. 108-58 at 84 (2003). As Judge Walker noted in his concurring opinion in *NAF v. Ashcroft*, following the *Stenberg* ruling, a bill containing the "same detailed factual findings that were ultimately enacted into law" was introduced before Congress held any additional hearings or considered any new evidence. 437 F.3d 279, 292 n.9 (2d Cir. 2006) (Walker, J., concurring).

[30] *See Hearing on the Partial-Birth Abortion Ban of 2002 Before the House Subcomm. on the Constitution of the Comm. on the Judiciary*, 107th Cong. (2002) (hereinafter, the "2002 House Hearing").

[31] Dr. Kathi Aultman, a board certified obstetrician-gynecologist, testified that there had not been any peer-reviewed, controlled studies on the comparative safety of D&X, and that in her view, it was a dangerous experimental procedure. *Id.* at 8. Dr. Cook appeared again and provided essentially the same testimony that he gave in 1997. *Id.* at 26.

[32] *Id.*, App. at 47-280. The amicus briefs that ACOG and the Association

In early 2003, H.R. 760 and S. 3, bills virtually identical to H.R. 4965, were simultaneously introduced in the House and Senate. The Senate held no hearings on the Ban, and it rejected a motion to recommit to the Judiciary Committee, even though it had not conducted any hearings on the issue since the 1997 Joint Hearing.[33]

In March 2003, the House Judiciary Committee's Subcommittee on the Constitution held the only hearing on the Ban, which lasted one hour and thirty minutes. During that hearing, one medical witness testified in person, Dr. Mark Neerhof. Dr. Neerhof supported the Ban and his testimony echoed the testimony previously provided by Dr. Pamela Smith.[34]

However, materials submitted to Congress by health care professionals identified the safety benefits of D&X and expressed concern that the Ban would jeopardize women's health by forcing women to undergo less safe procedures. Dr. Vanessa Cullins, former Assistant Professor at John Hopkins University and Vice President of Medical Affairs for Planned Parenthood Federation of America, submitted written testimony that, "D&X is within the accepted standard of care and is not only safe, but for some woman may be

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of American Physicians and Surgeons ("AAPS") filed with this Court in *Stenberg* were also entered into the record during the markup session held by the Subcommittee on the Constitution and were attached to the House Judiciary Committee's Report on H.R. 4965. H.R. Rep. 107-604 at 93-107, 110-134 (2002).

[33] *See* 149 Cong. Rec. S3428-29 (Mar. 11, 2003); 149 Cong. Rec. S3570 (Mar. 12, 2003); 149 Cong. Rec. S3580 (Mar. 12, 2003).

[34] Significantly, Dr. Neerhof's testimony reached the same conclusions as a journal article he had co-authored, *see* Sprang & Neerhof, "Rationale for Banning Abortions Late in Pregnancy," 280 *JAMA* 744 (Aug. 26, 1998), which was part of the record before Congress pre-*Stenberg* and which was cited in *Stenberg*. *See* 530 U.S. at 933; *id.* at 1016 n.22; *id.* at 1017.

safer than other abortion methods."[35] These professionals also pointed out that there was no basis for the alleged risks set forth in the Ban's Findings. Dr. Anne Davis, Assistant Professor in Clinical Obstetrics and Gynecology at Columbia University, stated that "[t]here is no data supporting the assertion that the gradual and gentle dilation involved in intact D&E causes cervical incompetence ... no support for the assertion that converting the pre-viable fetus to a breech presentation is dangerous, ... and the risk of laceration and of damage from blind insertion of instruments is decreased – not increased – by removing the fetus intact."[36]

In addition to the written statements of Drs. Cullins and Davis, four physicians submitted new letters opposing the Ban. Dr. Gerson Weiss, Professor and Chair of the Department of Obstetrics and Gynecology and Women's Health at New Jersey Medical College, and Dr. Natalie Roche, Assistant Professor, stated that D&X "is sometimes the physician's preferred method of termination" because it *reduces* the risk of uterine perforations, tears, and cervical lacerations.[37] Dr. Felicia H. Stewart, an Adjunct Professor in the Department of Obstetrics, Gynecology and Reproductive Sciences at the University of California, San Francisco, and co-director of the Center for Reproductive Health Research and Policy, stated that the "options left open" by the Ban "are less safe for women who need an abortion after the first trimester of pregnancy," and described a series of underlying medical conditions which dictate that physicians be given the latitude to terminate a pregnancy in the safest manner possible.[38]

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[35] *See* 2003 House Hearing at 187-88.

[36] *Id.* at 194.

[37] *See* 149 Cong. Rec. S3385-86 (Mar. 10, 2003).

[38] *See* 2003 House Hearing at 189-91.

To rebut the Ban's sponsor's claims that Congress had never been provided with a specific case in which D&X would be medically indicated, a letter from Dr. Philip Darney, Chief of Obstetrics, Gynecology and Reproductive Sciences at San Francisco General Hospital, was introduced into the record during the Senate floor debates, which provided two examples in which patients presented with placenta previa and placenta accreta, where the procedure was "critical to providing optimal care."[39] Moreover, Dr. Darney stated that he was certain that a review of records from this major metropolitan hospital, which performs 2,000 abortions annually, would identify other instances "in which 'intact D&E' was the safest technique of pregnancy termination" such as in cases of "severe pre-eclampsia."[40] In addition, ACOG, PRCH, AMWA, and APHA submitted material opposing the Ban.[41]

Eight physicians submitted new letters supporting the Ban. Seven of these letters expressed disagreement with the medical examples offered in Dr. Darney's letter.[42] Dr. Anthony P. Levatino wrote to confirm the accuracy of demonstrative exhibits prepared under his supervision, and did not address the safety or need for D&X.[43] PHACT submitted a summary of testimony offered to the Health and Welfare Committee of the Rhode Island Senate by William

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[39] 149 Cong. Rec. S3600 (Mar. 12, 2003).

[40] *Id.*

[41] *See* 149 Cong. Rec. S3479-80 (Mar. 11, 2003); 149 Cong. Rec. S3656-57 (Mar. 13, 2003); 149 Cong. Rec. S11596-97 (Sept. 17, 2003); 149 Cong. Rec. S12932-33 (Oct. 21, 2003); 2003 House Hearing at 201-209.

[42] *See* 2003 House Hearing at 102-112 (letters of Daniel J. Weshter, M.D.; Watson A. Bowes, Jr., M.D.; Steve Calvin, M.D.; Nathan Hoeldtke, M.D.; Byron C. Calhoun, M.D.; T. Murphy Goodwin, M.D.; and Susan E. Rutherford, M.D.).

[43] *Id.* at 62.

Cashore, M.D., which did not discuss the risks of D&X or argue that the procedure was unsafe, but did take issue with the view that the procedure is safer or better than other methods of termination.[44]

The legislation passed both chambers, and the President signed the Ban into law on November 5, 2003.

II. The Ban's Findings Are Not Supported by the Record

The Ban's Findings assert that "overwhelming evidence . . . much of which was compiled after the district court hearing in *Stenberg*" demonstrates that the banned procedures are "never necessary to preserve the health of a woman."[45] Yet, the *Stenberg* Court did not confine its review to the trial record,[46] and the legislative record clearly shows that Congress did not base its Findings on any new body of evidence, but rather on *the same information that this Court had considered in Stenberg*. Indeed, as the Congressional history outlined above demonstrates, Congress marshaled no new evidence in support of the Ban.[47]

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[44] *Id.* at 95-99.

[45] *See* 117 Stat. 1202, § 2(7); § 2(5).

[46] *See Stenberg*, 530 U.S. at 932-33 (evaluating other trial courts' evidence); *id.* at 927, 929 (discussing treatment of banned procedures by medical texts and journals); *id.* at 933 (relying upon amicus briefs submitted to Supreme Court); *id.* at 929-30 (reviewing Congressional record); *see also id.* at 960, 966 (Kennedy, J., dissenting); *id.* at 987 & n.5, 993-96 & nn.11 & 13, 1016-17 & n.23 (Thomas, J., dissenting).

[47] For example, the House Judiciary Committee's report in support of the Ban relied principally upon testimony received during the pre-*Stenberg* 104th and 105th Congresses and cited to little else than the policy statements of the AMA, the testimony of the State's lead expert in *Stenberg*, and the briefs the Petitioner and amici AAPS filed with this Court in support of Nebraska's ban. H.R. Rep.. No. 108-58 at 14-23 (2003). Likewise, the testimony of the five physicians who testified before Congress concerning the alleged dangers posed by the banned

Just as Congress embraced evidence that this Court had already considered and found lacking in *Stenberg*, its Findings fly in the face of a significant body of medical opinion establishing the safety and necessity of the banned procedure. For example, the record does not support Congress' Finding that D&X is a "disfavored procedure" among "physicians who routinely perform other abortion procedures."[48] Several physicians specializing in obstetrics and gynecology who regularly perform abortions stated that they use the procedure. *See e.g.*, 1996 House Hearing at 130 (Dr. William Rashbaum); *id.* at 132 (Dr. Herbert Jones); 149 Cong. Rec. S3600 (Mar. 12, 2003) (Dr. Darney).

Nor does the record support Congress' Finding that "[a] moral, medical, and ethical consensus exists" that D&X is "never medically necessary,"[49] or the Finding that the procedure "poses serious risks to a woman's health, and lies outside the standard of medical care."[50] Congress was provided with numerous examples of situations in which physicians employed the intact D&E procedure because it was the safest option to preserve the health of the patient, which standing alone, completely debunk the claim that the banned procedure is "*never* medically necessary." *See, e.g.*, 141 Cong. Rec. S17892 (Dec. 4, 1995) (Dr. Scommegna); 1996 House Hearing at 132 (Dr. Herbert Jones); 143 Cong.

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procedures did not differ in any material respect from information they had previously presented to the Court through an amicus brief, *see* Br. Amici Curiae Assoc. Am. Physicians & Surgeons et al., in Support of Pets., *Stenberg v. Carhart*, 530 U.S. 914 (2000) (No. 99-830), available at 2000 WL 228448 (including as amici Drs. Aultman, Cook, Romer, and Smith); *id.* at 933, or through a journal article previously considered by the Court. *See* 530 U.S. at 933 (discussing article co-authored by Dr. Neerhof).

[48] 117 Stat. 1201, § 2(2).

[49] 117 Stat. 1202, § 2(1).

[50] 117 Stat. 1202, § 2(13).

Rec. S4521 (May 15, 1997) (Dr. Grimes); 149 Cong. Rec. S3600 (Mar. 12, 2003) (Dr. Darney).[51] Congress also heard from physicians practicing in reproductive genetics and high-risk obstetrics who have referred their patients to other physicians who perform intact D&Es because of the health benefits the procedure offers. *See* 1995 Senate Hearing at 144; 141 Cong. Rec. S17891 (Dec. 4, 1995) (Dr. Laurence Burd). Congress had all of this medical authority available to it, explaining why in the opinion of knowledgeable and qualified physicians, the banned procedure is both safe and necessary, and within the accepted standard of care.[52]

The record flatly disproves Congress' assertion that there is "no credible evidence" that D&X is "safe or safer than other abortion procedures."[53] The record contained many explicit statements from physicians (many who had actual experience or familiarity with surgical abortions) and medical organizations (the majority of which opposed the

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[51] In the opinion of many obstetricians-gynecologists who submitted materials in opposing the Ban, D&X offers several safety advantages over alternative procedures and the risk of uterine tears and cervical lacerations is *reduced* – not increased – by removing the fetus intact. *See* 1995 Senate Hearing at 100-101 (Dr. Mary Campbell); 2003 House Hearing at 187-88 (Dr. Vanessa Cullins); *id.* at 194 (Dr. Anne Davis); 149 Cong. Rec. S3385-86 (Mar. 10, 2003) (Drs. Gerson Weiss and Natalie Roche). Physician witnesses who cited these risks and the risks associated with performing a breech extraction conceded that these alleged risks have not been adequately quantified. *See* 1995 Senate Hearing at 78-79 (Dr. Pamela Smith); 2003 House Hearing at 7 (Dr. Neerhof).

[52] Notably, even amici Congressman Ron Paul and the AAPS acknowledge that "the practice has been incorporated into abortion texts and the curriculum of prestigious medical schools. *See* Brief of Amici Curiae Congressman Ron Paul and Association of American Physicians and Surgeons in Support of Petitioner, at 19 (citing 331 F.Supp.2d at 1010); *see also Ashcroft*, 320 F.Supp.2d at 1029.

[53] 117 Stat. 1204, § 2(14)(B).

Ban) who believed D&X may be safer than other techniques in certain circumstances.[54] Finally, Congress knew that the ACOG, the nation's most reputable organization of practicing obstetricians and gynecologists, steadfastly opposed the Ban and continued to express its opinion that "there are circumstances under which this type of procedure would be the most appropriate and safest procedure to save the life or health of a woman."[55] Nevertheless, supporters of the Ban found and placed great emphasis on the fact that there are no controlled medical studies on the comparative safety of D&X, a point which this Court treated as irrelevant in light of the significant body of medical opinion, which both it and Congress had before it, attesting to its safety advantages.[56]

Based on the evidence before it – a far more compelling evidentiary record than this Court found to require a health exception in *Stenberg* – the Ban's supporters could not have reasonably inferred that D&X is unsafe, much

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[54] *See e.g.*, 1995 Senate Hearing at 60 (Dr. Mary Campbell); 1996 House Hearing at 132 (Dr. Herbert Jones); 141 Cong. Rec. S17892 (Dec. 4, 1995) (Dr. Antonio Scommegna); 141 Cong. Rec. S17890 (Dec. 4, 1995) (Dr. James Schreiber); 141 Cong. Rec. S18192 (Dec. 7, 1995) (Dr. Samuel Edwin); 143 Cong. Rec. S4521 (May 15, 1997) (Dr. David Grimes); 2003 House Hearing 187-88 (Dr. Vanessa Cullins); 149 Cong. Rec. S3385-86 (Mar. 10, 2003) (Drs. Gerson Weiss and Natalie Roche); 2003 House Hearing 189-91 (Dr. Felicia Stewart); 149 Cong. Rec. S3600 (Mar. 10, 2003) (Dr. Darney).

[55] *Compare* 149 Cong. Rec. S12921 (Oct. 21, 2003) (March 6, 2003 Letter from Ralph Hale, Exec. V.P. of ACOG, reaffirming the ACOG's Statement on Intact Dilation and Extraction, Jan. 12, 1997); H.R. Rep. 108-58, at 98 (Brief of Amici Curaie American College of Obstetricians and Gynecologists, et al., in Support of Respondent); 2003 House Hearing at 197 (ACOG July 8, 2002 Policy Statement on the Subject of "Partial-Birth Abortion" Bans) *with Stenberg*, 530 U.S. at 928, 932, 935-36 (citing the ACOG 1997 Policy Statement and brief of amici ACOG).

[56] *Compare* 117 Stat. 1204 at § 2(14)(B); H.R. Rep 108-58, at 14-15 *with Stenberg*, 530 U.S. at 936-37.

less concluded that a new found consensus exists that it is never medically necessary.

III. The Federal Abortion Ban Is Governed By This Court's Abortion Decisions

Proponents of this legislation could not have reasonably concluded that the Ban falls outside of this Court's abortion jurisprudence. Remarkably, members of Congress who join Petitioner in defending the Ban nevertheless retreat to the same strained argument posited and rejected when the Nebraska ban was before this Court in *Stenberg*. They submit that *Roe* and its progeny are not dispositive here since this Court's abortion decisions are about the "unborn," whereas this legislation concerns the "partially born."[57] Advancing an argument, which by the Ban's sponsor's own admission, is squarely foreclosed by *Stenberg*,[58] they claim that two of this Court's decisions – "presuppose" such a distinction.[59]

First, they reason that this Court somehow implicitly recognized in *Roe* that a two-tiered analysis should apply when the Court noted, without comment, that Texas' parturition statute, which prohibited one from killing a child "in the state of being born and before actual birth," was not under attack. *See Roe*, 410 U.S. at 118 n.1. Second, they rely on this Court's decision in *Planned Parenthood Association of Kansas City, Missouri, Inc. v. Ashcroft*, 462 U.S. 476, 485-86 (1983), which upheld a requirement that a second physician be available during certain emergency third

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[57] *See* Amicus Brief of the American Center for Law and Justice, 78 Members of Congress, and the Committee to Protect the Ban on Partial Birth Abortion in Support of Petitioner ("78 Members' Brief") at 9-11.

[58] 149 Cong. Rec. S11593 (Sept. 17, 2003) (statement of Sen. Santorum).

[59] 78 Members' Brief at 10.

trimester abortions to assist in preserving the life and health of a child. However, the statute in *Ashcroft* applied in those rare circumstances where a *viable* fetus survives the abortion procedure and a *live birth* occurs, and the Court said nothing about the State's ability to interfere with the first physician's efforts to preserve the woman's health. *Id.* That is because consistent with this Court's precedents,[60] the statute at issue there specifically provided that the second physician only takes "steps ... to preserve the life and health of the viable unborn child" which do "not pose an increased risk to the life or health of the woman." *Id.* at 483.

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[60] The principle that a mother's life and health, are at all times, paramount to all other interests the State might assert, is a bedrock of this Court's abortion jurisprudence. *See Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 879 (1992) (reaffirming *Roe*'s holding that a State may advance its interest in a viable fetus by regulating or proscribing abortion, only if an exception is made for circumstances where "it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother"). Indeed, this Court has never approved a ban on the performance of a particular abortion procedure, finding that such regulations impermissibly placed a mother's health at risk. *See Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 768-69 (1986) (facially invalidating statute which failed to require that maternal health be the physician's paramount concern), *overruled in part on other grounds by Casey*, 505 U.S. at 870, 882; *Coulautti v. Franklin*, 439 U.S. 379, 400 (1979) (declaring statute unconstitutionally vague which did not clearly allow the physician to put the life and health of the mother first, and left the door open to a "trade off" between maternal health and fetal survival that raised "serious ethical and constitutional difficulties"); *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52, 79 (1976) (finding ban which "force[d] a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed" unconstitutional). This Court's decision in *Stenberg* made clear that partial-birth abortion bans are to be treated no differently. *See Stenberg*, 530 U.S. at 937 (holding that State was unjustified in banning a procedure which may be safer for some patients without including a maternal health exception).

Under *Roe* and its progeny, a woman's health must always prevail, and this Court affirmed this protection when it invalidated a virtually identical ban in *Stenberg*. Therefore, members of Congress who defend this legislation cannot in good faith maintain that the Ban raises new questions that this Court has not previously examined.

The clear intent of the proponents of the Ban is made evident by a side-by-side comparison of the evidence Congress relied upon in enacting the statute and that which this Court rejected in *Stenberg*. In embracing this discredited evidence and reaching the opposite conclusion, Congress clearly sought to respond to this Court's earlier ruling in *Stenberg* and work a substantive change in general abortion law. The decision to omit a health exception was not based on any intervening change in medical fact, but founded upon a desire to challenge the prevailing constitutional standard that *Stenberg* reaffirmed.[61]

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[61] *See e.g.*, 149 Cong. Rec. S3606 (Mar. 12, 2003) (statement of Sen. Santorum – "To suggest we in Congress don't have the right to make these decisions, that we have to give it up to the courts – unelected people, just give it up to them; I don't need to be ruled by a bunch of judges"); 149 Cong. Rec. H4946 (June 4, 2003) (statement of Rep. DeLay – "I did not come to the House to make a decision for the courts. I came to the House to pass strong, important legislation, and then to fight in the courts for my position. I do not let the courts decide what direction I will go. If Members want to make decisions for the courts, then go down to the White House and get a nomination from the President"); 148 Cong. Rec. H5360 (July 24, 2002) (statement of Rep. Davis – "even if it were certain that this legislation as soon as it was passed would be struck down by an imperial judiciary, we must, as Members of Congress, discharge our duties to at least attempt to protect the civil rights of the most vulnerable, those least able to protect themselves").

IV. Five Successive Congresses Rejected Proposals To Include A Health Exception In Abortion Procedure Ban Legislation

Congress had ample opportunity to pass an abortion procedure ban with a health exception, but chose not to include one. *See* 149 Cong. Rec. S3605-07 (Mar. 12, 2003) (statement of Sen. Santorum – "[This amendment] strips out the language of the partial-birth abortion ban, replaces it with … the current law… To simply restate the law and then claim one is for the partial-birth abortion bill … falls hollow on the Chamber"); *see also* 149 Cong. Rec. S3577-78 (Mar. 12, 2003); 149 Cong. Rec. H4943 (June 4, 2003) (statement of Rep. King). Instead, supporters of the Ban were intent on passing a bill that contained no protection for the health of the woman, left no role for her treating physician, and entirely removed fetal viability from the constitutional equation.

1. 104th Congress. The first partial-birth abortion bill, H.R. 1833, contained no exception to protect the life or health of the pregnant woman and had only an affirmative defense for procedures necessary to save a woman's life.[62] Amendments replaced the affirmative defense with an exception for the pregnant woman's life.[63] Several members of the House and Senate attempted to offer and pass amendments providing for a health exception, but their efforts were rebuffed.[64] President Clinton vetoed H.R. 1833

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[62] *See* H.R. 1833, § 1531(e) (June 14, 1995).

[63] *See* 142 Cong. Rec. S18228 (Dec. 7, 1995) (Roll No. 596).

[64] *See* 141 Cong. Rec. S18034 (Boxer Amendment No. 3083) (Dec. 7, 1945); 142 Cong. Rec. H2895 (Mar. 27, 1996) (statement of Rep. Bielenson); H. Res. 389, 104th Cong. 2d Sess. (1996); *see also* 142 Cong. Rec. H2899 (Mar. 27, 1996) (statement of Rep. Frank); 142 Cong. Rec. H.2902 (Mar. 27, 1996) (statement of Rep. Schroeder); 142 Cong. Rec. H2903 (statement of Rep. Jackson-Lee) (Mar. 27, 1996); 142 Cong. Rec. H2928 (Mar. 27, 1996) (Roll No. 94).

because it did not include a health exception, and the veto was sustained.

2. 105th Congress. H.R. 1122, the second partial-birth abortion bill to be considered by Congress, also did not contain a health exception, only a narrow life exception.[65] The House Judiciary Committee rejected several proposed health exception amendments,[66] and the legislation was passed by the full House after consideration under a closed rule[67] limiting general debate and barring amendments.[68]

The Senate likewise considered and rejected two amendments to H.R. 1122 providing for a health exception,[69] and instead approved the legislation with an amendment relating to the life exception.[70] As in the previous session,

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[65] *See* H.R. 1122, § 1531(a) (Mar. 19, 1997).

[66] *See e.g.*, H.R. Rep. 105-24 at 21 (1997) (substitute amendment offered by Rep. Scott that "would ban post-viability abortions unless the abortionist determines the mother's life or 'health' is at risk" defeated in a roll call vote); *id.* (amendment offered by Rep. Jackson-Lee "to allow all pre-viability partial-birth abortions and to add an exception to the general prohibition of partial-birth abortions to allow the procedure if the abortionist determines that a mother's life or 'health' is at risk" defeated in a roll call vote); *id.* (amendment offered by Rep. Frank to add an exception for the "'physical health' of the mother" defeated in a roll call vote).

[67] *See* H.Res. 100, 105th Cong., 1st Sess. (1997).

[68] *See* 143 Cong. Rec. H1231 (Mar. 20, 1997) (Roll No. 65).

[69] *See* 143 Cong. Rec. S4614 (Feinstein Amendment No. 288) (prohibiting post-viability abortions except where "necessary to preserve the life of the woman or to avert serious adverse health consequences") (May 15, 1997) (Rec. Vote No. 69); 143 Cong. Rec. S4614-4615 (Daschle Amendment No. 289) ("It shall be unlawful for a physician to abort a viable fetus unless the physician certifies that the continuation of the pregnancy would threaten the mother's life or risk grievous injury to her physical health") (May 15, 1997) (Rec. Vote No. 70).

[70] *See* 143 Cong. Rec. S4715 (Oct. 8, 1997) (Roll No. 71).

House members attempted to win consideration of two amendments creating maternal health exceptions, but their requests were rejected,[71] and the bill was again submitted under a closed rule and agreed to by the House.[72] President Clinton again vetoed the legislation, and the Senate again was unable to garner the necessary votes to override the veto.

3. 106th Congress. During the next session of Congress, the House and Senate considered different versions of the procedure ban, S. 1692 and H.R. 3660, but neither version contained an exception for the health of the mother.[73] Members offered health exception amendments.[74] which

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[71] *See* H.R. Rep. 105-312 at 1 (1997) (motion of Rep. Slaughter for Hoyer amendment which would "ban all post-viability abortions except where continuation of the pregnancy would endanger the life of the woman or risk grievous injury to her health"); *id.* at 2 (motion of Rep. Slaughter for the Lowey amendment which would apply "only post-viability and would include an exception in order to avert serious adverse health consequences to the mother"); 143 Cong. Rec. H8640 (Oct. 8, 1997) (statement of Rep. Myrick).

[72] *See* H.Res. 262, 105th Cong. 1st Sess. (1997); 143 Cong. Rec. H8662-63 (Oct. 8, 1997) (Roll No. 500).

[73] *See* S. 1692, § 1531(a) (Oct. 5, 1999); H.R. 3660, § 1531(a) (Feb. 15, 1999).

[74] *See* 145 Cong. Rec. S12943 (Durbin Amendment No. 2319) (prohibiting post-viability abortions unless prior to abortion, the attending physician and an independent physician who will not perform nor be present during the procedure certifies that continuation of the pregnancy will threaten the life of the mother or risk grievous injury to her health) (Oct. 20, 1999) (Rec. Vote No. 335); *see also* 146 Cong. Rec. H.1773-1799 (H.R. 2149, the Hoyer-Greenwood-Taucher-Johnson "Late Term Restriction Act") (providing for a federal ban on all post-viability abortions except those needed to preserve the woman's life or to avert serious adverse health consequences) (Apr. 5, 2000); H.R. Rep. No. 106-559, (2000); 106th Cong., 2d Sess. at 2 (motion of Rep. Slaughter for Frank amendment, creating exception to "avert serious adverse long-term physical health consequences to the mother"); *id.* (motion by Rep. Slaughter for Edwards amendment banning post-viability abortions except where physician concludes abortion is "necessary to prevent the

were defeated or foreclosed by parliamentary procedures limiting debate or prohibiting amendments.[75] Ultimately, the differing versions of the procedure ban passed by the two chambers were never reconciled, in the wake of this Court's ruling in *Stenberg*.

4. 107th Congress. H.R. 4965, a bill substantially similar to the Federal Abortion Ban, was introduced in the House on June 19, 2002 and contained Findings virtually identical to those found in the Ban, including the Finding that D&X "is never medically necessary."[76] The bill was referred to the House Committee on the Judiciary the same day, and its Subcommittee on the Constitution held a markup session on July 17, 2002. During the markup session, three amendments were offered to include a health exception, which were all rejected.[77]

Again, the proposed legislation was submitted for consideration under a closed rule resolution.[78] During the Rules Committee session on July 23, 2002, four motions to make an amendment containing a health exception were made, and each was defeated.[79] Pursuant to the provisions of

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death of a woman or a substantial risk of serious impairment to her physical or mental health").

[75] *See* H. Res. 457, 106th Cong. 2d Sess. (2000); 146 Cong. Rec. H1778 (Apr. 5, 2000); 146 Cong. Rec. H1800 (Apr. 5, 2000) (Roll No. 103).

[76] *See* H.R. 4965, § 2(1) (June 19, 2002).

[77] *See* H.R. Rep. No. 107-604, House Subcomm. on the Constitution Markup Tr., at 59-77, 88-89, 138 (2002).

[78] *See* H. Res. 498, 107th Cong., 2d Sess. (2002).

[79] *See* H.R. Rep. No. 107-608, at 2 (2002) (motion by Rep. Frost for Edwards amendment which would "ban all post-viability abortions, except where the physician determines in good faith, according to his best medical judgment, that the abortion is necessary to prevent the death of the woman or to avert a substantial risk of serious impairment to her physical or mental health"); *id.* (motion by Rep. Slaughter for Baldwin

House Resolution 498, general debate on H.R. 4965 was confined to two hours, and no amendments or intervening motions were permitted except for a motion to recommit. Representative Baldwin moved to recommit to the Judiciary Committee, which motion failed.[80] The House then passed H.R. 4965,[81] but it was not considered by the Senate during that session.

5. 108th Congress. In February 2003, partial-birth abortion legislation lacking a maternal health exception was again proposed in each of the chambers.[82] During the House Subcommittee markup session of the House version of the bill, H.R. 760, Representatives Scott, Baldwin, and Jackson-Lee proposed an amendment that would have offered an exception to preserve the health of the pregnant woman, in accordance with *Casey* and *Stenberg*. This amendment was defeated in a party line vote.[83]

H.R. 760 was then reported to the House for consideration with one hour of general debate. The House spent one additional hour debating the Greenwood-Hoyer

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amendment which would include "an exception for the preservation of the life or health of the mother"); *id.* (motion by Rep. McGovern for Jackson-Lee amendment which would limit the ban to partial-birth abortions performed post-viability, and include "an exception to protect the health of the woman, as required by *Stenberg v. Carhart*"); *id.* at 3 (motion by Rep. McGovern for Hoyer amendment which would ban all post-viability abortions, "unless, in the medical judgment of the attending physician, it is necessary to preserve the life of the woman or to avert serious adverse health consequences to her").

[80] *See* 148 Cong. Rec. H5373 (July 24, 2002) (Roll No. 342).

[81] *Id.* (Roll No. 343).

[82] *See* H.R. 760 (Feb. 13, 2003); S. 3 (Feb. 14, 2003).

[83] *See* H.R. Rep. No. 108-58, House Subcomm. on the Constitution Markup Tr., at 66-73 (2003) (amendment to include an exception where the abortion "is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother").

Amendment,[84] which permitted the banned procedure only where necessary to protect the woman from serious adverse health consequences.[85] The Ban's proponents rejected this and other proposals, including a still narrower version of this amendment that would have limited its application to serious physical health consequences which was not permitted to be voted upon by the full House.[86] Representative Baldwin moved to recommit to the Judiciary Committee, but the motion failed.[87] The House voted to pass H.R. 760,[88] and moved to replace the language of the Senate bill with the provisions of H.R. 760.[89]

Two amendments proposing a health exception were offered during the floor debates of S.3. Both were rejected.[90]

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[84] *See* 2003 House Hearing, App. at 50; 149 Cong. Rec. H1771-1775 (Apr. 5, 2000).

[85] *See* 149 Cong. Rec. H4939 (Greenwood Amendment) (prohibiting all post-viability abortions except where, in the medical judgment of the attending physician, the abortion is necessary to preserve the life of the woman or to avert serious adverse health consequences to the woman) (June 4, 2003) (Roll No. 240).

[86] *See* 149 Cong. Rec. H4915 (June 4, 2003); 149 Cong. Rec. H4910 (June 4, 2003) (statement of Rep. Delahunt).

[87] *See* 149 Cong. Rec. H4948-50 (June 4, 2003) (Roll No. 241).

[88] *See* 149 Cong. Rec. H4922-23 (June 4, 2003).

[89] *See* 149 Cong. Rec. H4951-53 (June 4, 2003) (agreed to by voice vote).

[90] *See* 149 Cong. Rec. S3479-3482 (Durbin Amendment No. 259) (prohibiting post-viability abortions unless prior to abortion, the attending physician and an independent physician who will not perform nor be present during the procedure certifies that continuation of the pregnancy will threaten the life of the mother or risk grievous injury to her health) (Mar. 11, 2003) (Rec. Vote No. 46); 149 Cong. Rec. S3600-3611 (Feinstein Amendment No. 261) (prohibiting all post-viability abortions unless, in the medical judgment of the attending physician, the abortion is necessary to preserve the life or health of the woman) (Mar. 12, 2003) (Rec. Vote No. 249).

Supporters of this legislation have generally opposed such amendments, arguing that a maternal health exception that can be interpreted broadly by physicians will undercut the efficacy of the ban.[91] In the interest of providing the women who would be affected by this law some protection, many of amici proposed that Congress concentrate instead on crafting a more circumscribed health exception.[92] That these proposals failed is telling. Of greater import, though, is the fact that in the eight years that the legislation at issue was under consideration, proponents of the Ban never offered anything in the way of a counter-proposal to limit the factors to be considered in applying a health exception. Retired Justice O'Connor even provided Congress with a roadmap for drafting legislation that might cure some of the constitutional infirmities of the Ban. *Stenberg*, 530 U.S. at 950-51. The legislative record, however, shows that the clear intent of the proponents of the Ban was to defy this Court's decision in *Stenberg* and whittle away at *Roe's* core principles. As five successive Congresses, in dozens of recorded votes, refused to adopt any health exception, it would violate the intent of Congress to create such an exception by judicial fiat.

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[91] *See, e.g.*, 149 Cong. Rec. S11592-94 (Sept. 17, 2003) (statement of Sen. Santorum – health "is an exception that swallows the rule"); 149 Cong. Rec. H4944 (June 4, 2003) (statement of Rep. Gingrey – opposing health exception for "serious adverse" health consequences since "[t]here are physicians who, unfortunately, and for generous consultation fee, will readily certify that a woman's health is endangered by the pregnancy").

[92] *See e.g.*, 149 Cong. Rec. H. 4941 (June 4, 2003) (statement of Rep. Greenwood – "If the issue here is that we want to make sure that this procedure is only used where health requirements demand it, then we should be working together to create a very tight health exception not eliminating one entirely").

V. Facial Invalidation of the Ban Is the Only Appropriate Remedy

In devising judicial remedies, this Court should resist any inclination to invade the legislative domain and rewrite an unconstitutional statute, even if in doing so it seeks to save the legislation. *Ayotte*, 126 S. Ct. 961, 968 (2006). As this Court stressed in *Ayotte*, the "touchstone" for any remedial analysis must be legislative intent. *Id.* As the legislative history of the Ban makes clear, Congressional supporters of the Ban prefer no law to a law with a maternal health exception.[93]

Nor should this Court remand this action back to the lower federal courts to determine Congress' intent as to whether it would consider having a law with a maternal health exception. The Ninth Circuit already conducted a thorough and detailed analysis of the legislative history and rightly concluded that "[Congress] considered the omission of the exception to be a critical component of the legislation it was enacting." *Planned Parenthood Federation of America, Inc. v. Gonzales*, 435 F.3d 1163, 1186 (9th Cir. 2006).[94]

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[93] *See e.g.*, 149 Cong. Rec. S3573-74, S3604-05 (Mar. 12, 2003) (statement of Sen. DeWine); 149 Cong. Rec. S3577-78, S3608 (Mar. 12, 2003) (statement of Sen. Santorum); 149 Cong. Rec. S12943 (Oct. 21, 2003) (statement of Sen. Santorum); 149 Cong. Rec. H4939 (June 4, 2003) (statements of Rep. Franks and Rep. Sensenbrenner); 149 Cong. Rec. H4991 (June 4, 2003) (statement of Rep. Chabot); 149 Cong. Rec. H 4992 (June 4, 2003) (statement of Rep. King); 149 Cong. Rec. H4944 (June 4, 2003) (statement of Rep. Gingrey); 149 Cong. Rec. H4944 (June 4, 2003) (statement of Rep. Renzi); 149 Cong. Rec. H4995 (June 4, 2003) (statement of Rep. Davis); 149 Cong. Rec. H4947 (June 4, 2003) (statement of Rep. Hostettler).

[94] Notably, not one of the briefs submitted by Congressional amici dispute this fact or attempt to mask Congress' disdain for the prevailing constitutional standard. *See* 78 Members Brief, at 8 ("[i]nvoking an adult's 'health' as a reason for killing an innocent child should be unthinkable in a civilized society"); Brief of Amici Curiae American

To salvage this statute would require the Court to graft onto the Ban a health exception, which those who voted for the Ban deliberately rejected. Since it would be impossible to cure the constitutional defect in this statute and remain faithful to legislative intent, the only appropriate remedy is for this Court to affirm the decisions of the Eighth and Ninth Circuits invalidating the statute *in toto*. Whether and how a new statute should be drafted to conform to the current state of medical knowledge and this Court's constitutional requirements must be left to another Congress to decide.

Association of Pro Life Obstetricians, Sen. Tom Coburn, M.D., Congressman Charles Boustany, J.R., M.D., Congressman Michael Burgess, M.D., Congressman Phil Gingrey, M.D., Congressman Dave Weldon, M.D., C. Everett Koop, M.D., Edmund D. Pellegrino, M.D. in Support of Petitioner at 3-5 (contending that the governing standard "medically necessary to preserve the health of the woman" means "any abortion a provider agrees to perform for any reason" and urging this Court to reject the definition of health set forth in its prior precedents); Brief of Amici Curiae Congressman Ron Paul and Association of American Physicians and Surgeons in Support of Petitioner, at 9 (maintaining that "the willingness of some abortion providers and courts to define any pregnancy as a health risk justifying abortion" supports "Congress' determination that a health exception is neither necessary or desirable in this legislation").

CONCLUSION

For the foregoing reasons, as well as those in the Respondents' Briefs, the judgments of the Courts of Appeals should be *affirmed.*

Respectfully submitted,

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Appendix A
Amici Curiae – Members of Congress

Rep. Gary L. Ackerman

Rep. Tom Allen

Rep. Tammy Baldwin

Rep. Shelley Berkley

Rep. Howard L. Berman

Sen. Barbara Boxer

Rep. Lois Capps

Rep. Michael E. Capuano

Rep. John Conyers, Jr.

Rep. Danny K. Davis

Rep. Susan Davis

Rep. Peter DeFazio

Rep. Diana DeGette

Rep. Lane Evans

Rep. Sam Farr

Rep. Chaka Fattah

Rep. Bob Filner

Rep. Raul Grijalva

Rep. Jane Harman

Rep. Rush Holt

Rep. Michael Honda

Rep. Steve Israel

Rep. Jesse Jackson, Jr.

Rep. Sheila Jackson Lee

Rep. Carolyn Cheeks Kilpatrick

Rep. Dennis J. Kucinich

Sen. Frank Lautenberg

Rep. John Lewis

Rep. Nita Lowey

Rep. Carolyn Maloney

Rep. Carolyn McCarthy

Rep. Betty McCollum

Rep. Jim McDermott

Rep. James P. McGovern

Rep. Martin T. Meehan

Sen. Patty Murray

Rep. Jerrold Nadler

Rep. John W. Olver

Rep. Linda Sanchez

Rep. Janice Schakowsky

Rep. Brad Sherman

Rep. Louise M. Slaughter

Rep. Hilda Solis

Rep. Fortney Pete Stark

Rep. Ellen Tauscher

Rep. Bennie Thompson

Rep. Mike Thompson

Rep. Edolphus Towns

Rep. Debbie Wasserman Schultz

Rep. Maxine Waters

Rep. Henry Waxman

Rep. Robert Wexler

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Nos. 05-1382, 05-380

In the

Supreme Court of the United States

ALBERTO R. GONZALES, ATTORNEY GENERAL,
Petitioner,

v.

PLANNED PARENTHOOD FEDERATION OF AMERICA, ET AL.,
Respondents.

ALBERTO R. GONZALES, ATTORNEY GENERAL,
Petitioner,

v.

LEROY CARHART, ET AL.,
Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURTS OF APPEALS FOR THE NINTH AND EIGHTH CIRCUITS

BRIEF OF *AMICI CURIAE* FORMER FEDERAL PROSECUTORS IN SUPPORT OF RESPONDENTS

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BRIEF OF *AMICI CURIAE*

INTEREST OF *AMICI CURIAE*[1]

Zachary W. Carter, former United States Attorney for the Eastern District of New York; Kendall Coffey, former United States Attorney for the Southern District of Florida; James E. Johnson, former Assistant United States Attorney and Deputy Chief of the Criminal Division for the Southern District of New York; Scott R. Lassar, former United States Attorney for the Northern District of Illinois; Laurie L. Levenson, former Assistant United States Attorney for the Central District of California; Loretta Lynch, former United States Attorney for the Eastern District of New York; Denise E. O'Donnell, former United States Attorney for the Western District of New York; Kristine Olson, former United States Attorney for the District of Oregon; Mark F. Pomerantz, former Assistant United States Attorney and Chief of the Criminal Division of the United States Attorney's Office for the Southern District of New York; William W. Robertson, former United States Attorney for the District of New Jersey; and James Robinson, former United

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[1] All parties in the matter *Gonzales* v. *Planned Parenthood, et al.*, No. 05-1382, and in the matter *Gonzales* v. *Carhart, et al.*, No. 05-380, have consented to the filing of this *Amici Curiae* brief, as evidenced by letters of consent filed with the Clerk. *Amici* are filing an Motion for Leave to File A Brief Of *Amici Curiae* Former Federal Prosecutors In Support of Respondents in *Gonzales* v. *Carhart, et al.*, No. 05-380. *Amici* are not related in any way to any party in this case, and no party or its counsel has authored any part of this brief. No person or entity other than *Amici* and their counsel has made any monetary contribution to the preparation of this brief.

States Attorney for the Eastern District of Michigan, are former federal prosecutors who have an interest in the effective functioning of the criminal justice system.

Amici are concerned that the unconstitutionally broad scope and vagueness of the Federal Partial-Birth Abortion Ban Act of 2003 threaten the criminal justice system by undermining the public's faith in the fairness of the system and the impartiality of prosecutors. Further, *Amici* are concerned that the Federal Abortion Ban puts prosecutors in the untenable position of prosecuting a law that directly conflicts with their traditional role to protect public health and safety, particularly where the medical profession disagrees on the necessity for certain procedures and the Ban was enacted in a highly-charged political environment. For these reasons, as explained further below, *Amici* urge the Court to affirm the decisions below.

STATEMENT OF THE CASE

Amici adopt Respondents' Statement in this case and Respondents' Statement in *Gonzales* v. *Carhart* and note the following facts relevant to the legal discussion in this brief.

The Federal Partial-Birth Abortion Ban Act (the "Federal Abortion Ban" or "Ban") was enacted in 2003, in response to this Court's decision in *Stenberg* v. *Carhart* declaring a Nebraska "partial-birth" abortion statute unconstitutional. The Ban seeks to outlaw abortion procedures referred to vaguely as "partial-birth abortions" and, like the unconstitutional Nebraska law, the Ban lacks any exception for the health of the woman. Any physician who violates the Ban may be imprisoned for up to two years and faces civil liability.

Every court to consider the Federal Abortion Ban has found it to be unconstitutional. The findings made by three district courts and the opinions of three appellate courts declaring the Ban unconstitutional confirm not only a widespread belief among physicians that the prohibited procedures are sometimes the best means to preserve a woman's health, but also that the Ban is unconstitutionally vague and overbroad and imposes an undue burden on a woman's constitutional right to choose to have a previability abortion. Moreover, the Ban fails to provide fair warning to those it regulates, prohibits the use of most second trimester abortion procedures, and threatens to chill the use of other necessary, and constitutionally protected, reproductive health services.

After carefully considering the evidence, the District Court for the Northern District of California held that the Ban is inconsistent with this Court's precedent and unconstitutional. The district court below first held that the Ban is facially invalid under *Stenberg*, for failing to include a health exception. Further, after hearing the testimony of numerous physicians and considering hundreds of exhibits, the district court concluded that the Ban's definition of "partial-birth abortion" encompasses not only intact D&E abortions but also non-intact D&Es,[2] certain inductions, and the treatment of some spontaneous

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[2] As defined by the Ninth Circuit, a non-intact D&E is a method of performing an abortion in which a doctor first dilates a woman's cervix and then, under ultrasound guidance, grasps a fetal extremity with forceps and attempts to bring the fetus through the cervix. In an intact D&E, also referred to as a D&X, the doctor first will dilate the woman's cervix. Rather than using multiple passes to disarticulate and remove the fetus, the doctor removes the fetus in one pass, without any disarticulation. *See Planned Parenthood Fed'n of Am.* v. *Gonzales*, 435 F.3d 1163, 1167 (9th Cir. 2006). The D&E procedures account for 85 to 95 percent of post-first trimester abortions. *Id.* at 1166.

miscarriages. *Planned Parenthood Fed'n of Am.* v. *Ashcroft*, 320 F. Supp. 2d 957, 973-74 (N.D. Cal. 2004). As a result, the court found the statute's language overbroad, thereby imposing an undue burden on women because physicians face prosecution and imprisonment for performing almost *any* second trimester abortion procedure. *Id.* at 974. The court also found the Ban unconstitutionally vague because, as physicians' trial testimony confirmed, the terms employed in the Ban do not clearly define the prohibited medical procedures; the Ban therefore deprives physicians of the fair notice that would enable them to conform their conduct to the law, and encourages arbitrary enforcement. *Id.* at 976-78.

The Ninth Circuit affirmed the district court's findings of overbreadth and vagueness. The court of appeals found that Congress, in drafting the Ban, deliberately chose not to follow this Court's precedent and instead defined the prohibited procedure to include most second trimester abortion procedures. *Planned Parenthood Fed'n of Am.* v. *Gonzales*, 435 F.3d 1163, 1177 (9th Cir. 2006). Further, because of its overbroad compass, the Ban has a chilling effect on doctors performing any previability second trimester abortion, and the Ban's scienter requirements do not cure this constitutional infirmity. *Id.* at 1177-79. The Ninth Circuit also found the Ban unconstitutionally vague "[b]ecause neither the statute when read as a whole nor its individual components provide fair warning of the prohibited conduct to those it regulates and because the Act permits arbitrary and discriminatory enforcement." *Id.* at 1184. Finally, because Congress deliberately drafted the Ban to be broader than the permissible statute outlined in *Stenberg*, the court of appeals found that the narrowest possible remedy was to permanently enjoin enforcement of the Ban in its entirety. *Id.* at 1191.

The courts in the Eighth and Second Circuits to consider the Ban likewise have enjoined enforcement of the Ban. The United States District Court for the District of Nebraska found the Federal Ban unconstitutional for two distinct reasons. First, the court found that an intact D&E is sometimes the safest abortion procedure to preserve the health of women and that Congress' finding to the contrary was not supported by competent medical evidence. *Carhart* v. *Ashcroft*, 331 F. Supp. 2d 805, 1017 (D. Neb. 2004). That same court made the same findings when considering Nebraska's "partial-birth" abortion ban in *Stenberg*—findings that this Court found to be "highly plausible" and "record based." *Id.* at 1017 n.147; *Stenberg* v. *Carhart*, 530 U.S. 914, 936 (2002). Second, the court found that the law applies to some non-intact D&E procedures as well as intact D&Es and is thus unconstitutionally overbroad. *Carhart* v. *Ashcroft*, 331 F. Supp. 2d at 1030-37.[3]

The Eighth Circuit affirmed. Finding that substantial medical authority supports the proposition that intact D&Es are sometimes necessary to protect a woman's health, the court found the Ban unconstitutional for its lack of a health exception. *Carhart* v. *Gonzales*, 413 F.3d 791, 802 (8th Cir. 2005). Because this alone invalidated the Ban, the court did not reach the issues of undue burden or vagueness. *Id.* at 803-04.

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[3] While the court suggested that the Government's "specific intent" construction might save the Ban from being unconstitutionally vague, it noted, as did the Ninth Circuit, that Congress had "stubbornly refused to follow the Supreme Court's suggestions for clarity" and that it would not be surprised to be overturned on this point because if the Government's construction were improper then "the Act is hopelessly vague regarding the medical procedures to which it applies." *Carhart* v. *Ashcroft*, 331 F. Supp. 2d at 1037.

Both the United States District Court for the Southern District of New York and the United States Court of Appeals for the Second Circuit also found the Ban unconstitutional for lack of a health exception. Each court noted that the evidence Congress considered belies its own conclusions: the congressional record demonstrates that a significant body of medical opinion holds that the intact D&E procedure is sometimes necessary to safeguard a woman's health. *Nat'l Abortion Fed'n* v. *Gonzales*, 437 F.3d 278, 287 (2d Cir. 2006); *Nat'l Abortion Fed'n* v. *Ashcroft*, 330 F. Supp. 2d 436, 489 (S.D.N.Y. 2004).

This Court granted certiorari in the present case and in *Gonzales* v. *Carhart* to consider the constitutionality of the Federal Abortion Ban. For the reasons set forth below, the decisions of both the Ninth Circuit and the Eighth Circuit should be affirmed and the Ban held unconstitutional.

SUMMARY OF ARGUMENT

The Federal Abortion Ban is unconstitutionally vague and overbroad and poses a significant threat to the effective functioning of the criminal justice system. The Ban is vague because it fails to provide adequate notice of what procedures it covers, and it is unconstitutionally overbroad because it encompasses within its broad scope most second trimester abortion procedures. The natural consequence of the statute's vagueness and overbreadth is to deter medical professionals from performing necessary medical procedures, even when such action is constitutionally protected and in the best interests of their patients. Where, as here, doctors are forced to choose between criminal liability and the best interests of their patients, it can only be assumed that enforcement of such a law will discourage doctors from performing any type of second trimester abortion procedure at all. This is true even where the

abortion procedure is constitutionally protected under this Court's precedents in *Roe* and *Casey*, and even when it is necessary to protect the health, and indeed the life, of the patient.

But the Ban threatens not only the due process rights of medical professionals and the health of their patients; it threatens the integrity of the criminal justice system. In order to function effectively, the criminal justice system must be correctly perceived by the public to operate fairly and judiciously. A vague and overbroad criminal law such as the Federal Abortion Ban, however, threatens the system by permitting arbitrary and discriminatory enforcement, particularly where, as here, its enactment was politically motivated and highly charged. This backdrop creates the unfortunate image in the public's eye that some prosecutors may enforce this law in accordance with their own personal political views, and undermines the independence of prosecutors. The Ban is unconstitutional and the Court accordingly should affirm the decisions below.

ARGUMENT

I.

THE FEDERAL ABORTION BAN IS UNCONSTITUTIONALLY VAGUE AND THREATENS THE INTEGRITY OF THE CRIMINAL JUSTICE SYSTEM

The Ban is unconstitutional for lack of due process because it does not provide sufficient specificity to "enable the ordinary citizen to conform his or her conduct to the law," *City of Chicago* v. *Morales*, 527 U.S. 41, 58 (1999); *see also Grayned* v. *City of Rockford*, 408 U.S. 104, 108 (1972);

Lanzetta v. *New Jersey*, 306 U.S. 451, 453 (1939); *Connally* v. *Gen. Constr. Co.*, 269 U.S. 385, 393 (1926), nor does it "provide explicit standards for those who apply them." *Grayned*, 408 U.S. at 108. The degree of specificity required is greater where, as here, the statute imposes criminal sanctions. *See Vill. of Hoffman Estates* v. *Flipside, Hoffman Estates, Inc.*, 455 U.S. 489, 498-99 (1982); *see also Colautti* v. *Franklin*, 439 U.S. 379, 390 (1979), *overruled in part on other grounds*. Moreover, where statutes permit multiple interpretations, they delegate "basic policy matters to policemen, judges, and juries for resolution on an ad hoc and subjective basis," denying citizens the notice required by the Fifth Amendment, and permitting arbitrary and discriminatory enforcement. *Grayned*, 408 U.S. at 108-09. That is this case.

A. The Federal Abortion Ban Is Unconstitutionally Vague Because It Fails to Clearly Define the Medical Procedures That It Prohibits

The Federal Abortion Ban is unconstitutionally vague because, as the court of appeals correctly found, the Ban "fails to define clearly the medical procedures it prohibits." *Planned Parenthood Fed'n of Am.* v. *Gonzales*, 435 F.3d at 1181. Courts, doctors, and, in fact, the Government, all have found the statute susceptible to multiple interpretations, and its terms so ambiguous that the Ban fails to provide the specificity required of a criminal law under the U.S. Constitution.

The Federal Abortion Ban outlaws "partial-birth abortions," 18 U.S.C. § 153(a), a term with no medical or legal significance. *Planned Parenthood Fed'n of Am.* v. *Gonzales*, 435 F.3d at 1181; *Planned Parenthood of Cent. N.J.* v. *Farmer*, 220 F.3d 127, 136 (3d Cir. 2000); *Planned Parenthood of Greater Iowa, Inc.* v. *Miller*, 30 F. Supp. 2d 1157, 1165 (S.D. Iowa 1998), *aff'd*, 195 F.3d 386 (8th Cir. 1999). The statute

purports to prohibit *all* abortions where the doctor "deliberately and intentionally vaginally delivers a living fetus" up until a point on the fetus "for the purpose of performing an *overt act* that the person knows will kill the partially delivered fetus" and "perform[s] the overt act, other than completion of delivery." 18 U.S.C. § 153(a). But, this definition fails to provide any clarity as to what procedures are prohibited, and thus fails constitutional due process requirements.

As the district court and the court of appeals unanimously held, the Federal Abortion Ban may be read to cover an innumerable amount of conduct and, therefore, is unconstitutionally vague. The Government erroneously argues that "overt act" is a "standard statutory term of art," that "when read in context . . . obviously refers to an act that is distinct from the act of partial delivery." (Pet. Br. at 38-39.) As many doctors testified below, an "overt act" could "comprise many acts, performed not only in the process of an intact D&E, but in the course of a D&E by disarticulation (a non-intact D&E) or induction as well, including disarticulation of the calvarium, cutting the umbilical cord, or compressing or decompressing the skull or abdomen or other fetal part that is obstructing completion of the uterine evacuation." *Planned Parenthood Fed'n of Am.* v. *Ashcroft*, 320 F. Supp. 2d at 978. Moreover, the phrase "other than the completion of delivery" does not provide the context necessary to cure the statute of its vagueness. It is unclear on its face what procedures "complete a delivery." And, the term "living fetus" only contributes to the statute's vagueness, as the term broadly applies prior to viability, and the "overt act" prohibited thus could take place during any number of medical procedures.

Contrary to the Government's assertions, the Ban's operational provisions cannot be read to render clear guidance about which procedures are prohibited. (Pet. Br. at 37.)

Tellingly, the Government itself cannot agree on one construction and instead has defined the banned procedure in varying ways. *Compare Planned Parenthood Fed'n of Am.* v. *Ashcroft*, 320 F. Supp. 2d at 969 *with* Pet. Br. at 33. In the lower courts, the Government's position "[was] simply that . . . the Act is not vague and should be interpreted to apply only to intact D&E abortions—not to D&Es by disarticulation, inductions, or other abortion procedures." *Planned Parenthood Fed'n of America* v. *Ashcroft*, 320 F. Supp. 2d at 969. In its brief before this Court, however, the Government now contends that an abortion by dismemberment beyond a specified anatomical landmark—as set by Congress not physicians—would constitute "an especially gruesome form of the partial-birth abortion procedure that the Act seeks to outlaw." (Pet. Br. at 33.) These contradictory positions confirm the vagueness of the statute and why it would be unconstitutional for prosecutors to penalize physicians under such an ambiguous law.

Furthermore, the Ban's specific provisions, such as the phrase "living fetus," are hopelessly vague as a legal proscription. *Planned Parenthood Fed'n of Am.* v. *Ashcroft*, 320 F. Supp. 2d at 1183-84. As many courts have recognized in considering similar language, "reasonable physicians differ as to the meaning of what is 'living.'" *Planned Parenthood of S. Ariz.* v. *Woods*, 982 F. Supp. 1369, 1379 (D. Ariz. 1997). Indeed, courts almost universally have found that the term "living fetus" is unconstitutionally vague. *See Farmer*, 220 F.3d at 136-37 (finding "living human fetus" to be vague); *Richmond Med. Ctr. for Women* v. *Gilmore*, 55 F. Supp. 2d 441, 496 (E.D. Va. 1999) (same), *aff'd*, 224 F.3d 337 (4th Cir. 2000) (on undue burden grounds); *A Choice for Women* v. *Butterworth*, 54 F. Supp. 2d 1148, 1158 (S.D. Fla. 1998) (same). It is unclear whether a "living fetus" must be intact, *Miller*, 30 F. Supp. 2d at 1165 ("[i]t is not clear whether 'living fetus' refers only to an intact fetus with a heartbeat or some other form

of 'life,' or to a disarticulated fetus with a heartbeat or some other sign of 'life'"), or whether "living" is defined by some other criterion, *compare Woods*, 982 F. Supp. at 1379 (questioning whether a "living fetus" is simply a collection of living cells) *with Planned Parenthood Fed'n of America* v. *Ashcroft*, 320 F. Supp. 2d at 971 (defining living fetus as "pulsing umbilical cord" or heartbeat). A physician or prosecutor could not possibly know whether a given "overt act" "kill"-ed the fetus under the Ban without having a clear definition of what made it "living." *See Richmond Med. Ctr. for Women*, 55 F. Supp. 2d at 496; *Woods*, 982 F. Supp. at 1379. For these reasons too, the statute is plainly unconstitutional.

Contrary to the Government's contention, the statute's scienter requirements do not remedy the vagueness and may even contribute to it. "A scienter requirement applied to an element that is itself vague does not cure the provision's overall vagueness." *Planned Parenthood Fed'n of Am.* v. *Gonzales*, 435 F.3d at 1184; *see also Miller*, 30 F. Supp. 2d at 1166. A physician may "knowingly" or "deliberately and intentionally" perform a given action and still not be certain whether he or she has violated the Ban. This renders the statute unconstitutional for several compelling reasons.

First, as the court of appeals noted but did not resolve, it is disputed whether the "deliberately and intentionally" requirement modifies only "vaginally delivers" or the entire subsection relating to placement of the fetus. *Planned Parenthood Fed'n of Am.* v. *Gonzales*, 435 F.3d at 1180 n.22. This distinction has real and substantial consequences for a physician because it is virtually impossible to know with precision where a fetus is located at any given point during a medical procedure that simply cannot be stopped once begun. *See, e.g.*, *Carhart* v. *Ashcroft*, 331 F. Supp. 2d at 860 (testimony of Dr. Knorr that the cervix and sometimes part or all of the

uterus extends outside the vagina in four to six percent of his second trimester abortion patients); *id.* at 989 (testimony of Dr. Hammond that the location of the cervix in relation to the vaginal opening sometimes "evolves during the course of the surgery" and as a result "in the reality of an operating room, it is hard to tell when the fetus is outside the woman's body"). When faced with potential criminal liability, physicians should know for certain whether they risk criminal sanctions for failing to adequately monitor a fetus' placement (even were such monitoring possible at the start of the procedure). The Ban fails to provide such notice.

Moreover, the statute itself does not resolve the issue of *when* a physician must form the requisite intent to violate the Ban. The Government seeks to evade this critical issue by arguing that the Ban "applies only where the person performing the abortion has the specific intent, at the outset of the procedure, to deliver the requisite portion of the fetus of the purpose of performing the lethal act." (Pet. Br. at 32.) The Government's position, however, finds no support in the statutory text. Contrary to the Government's contention, it is unclear from the statute whether the Ban applies only to a physician who formed the specific intent from the outset or also to a physician who "knows" that in the course of an otherwise legal abortion procedure complications may arise that unintentionally result in a procedure that meets the Ban's proscriptions. *See Carhart* v. *Ashcroft*, 331 F. Supp. 2d at 1039 ("[a]rguably, use of the word 'knows' dilutes the specific intent required by the use of the word 'purpose' in the same sentence"). A physician should not be required to make the untenable choice between criminal liability and patient health. The statute is unconstitutional.

B. The Life Exception to the Federal Abortion Ban Also Is Unconstitutionally Vague

Adding significantly to the vagueness of the Federal Abortion Ban is the severely limited and vague life exception. The Ban exempts from prosecution procedures that are "necessary to save the life of a mother whose life is endangered by a physical disorder, physical illness, or physical injury . . . ." 18 U.S.C. §1531(a). Particularly given the absence of a health exception, the statute's narrow life exception does not properly inform the prosecutor when a "threat to health" becomes a "threat to life," and thus is constitutionally deficient.[4]

First and foremost, the life exception is vague as to what is "necessary to save the life" of a mother. The Ban's language thus forces doctors, prosecutors, and courts to determine on an ad hoc basis when a threat to health (which the statute, unconstitutionally, does not exempt) becomes a sufficient threat to life. Prosecutors and courts will be placed in the untenable position of second guessing a physician's best medical judgment. For example, when presented with a physician who performed a banned procedure and her patient lived, prosecutors and courts will be forced, after the fact, to determine whether there was a threat to the health of the patient or a threat to her

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[4] *Amici* believe that the Ban's lack of a health exception renders the statute unconstitutional. *Amici* submit that there simply is no legitimate reason not to include a health exception in a statute that addresses a medical procedure. In truth, by so narrowly restricting the life exception compounded with the vagueness in the life exception—Congress has created a greater risk to women's health and lives which this Court should not countenance.

life. It not only is unclear how prosecutors and courts should draw that line, but it is almost impossible to do so.[5]

This Court has long recognized the importance of allowing physicians to exercise their best medical judgment, unencumbered by fear of criminal prosecution. *See, e.g.*, *Doe* v. *Bolton*, 410 U.S. 179, 199 (1973) (holding that a physician's best judgment whether a there is a threat to the life or health of their patient "should be sufficient"); *see also United States* v. *Vuitch*, 402 U.S. 62, 70-71 (1971) ("It would be highly anomalous for a legislature to authorize abortions necessary for life or health and then to demand that a doctor, upon pain of one to ten years' imprisonment, bear the burden of proving that an abortion he performed fell within that category.").[6] The

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[5] Moreover, the statute is vague for the additional reason that the life exception lacks a mens rea requirement. The lack of a mens rea requirement renders the ban a strict liability statute, under which a doctor who performs a banned procedure, believing reasonably *and* in her best medical judgment that the procedure is necessary to save the life of her patient, may nonetheless be criminally liable if, in retrospect, a prosecutor determines that the doctor was wrong about the life saving need for the procedure. *But see Carhart* v. *Ashcroft*, 331 F. Supp. 2d at 1041-42 (accepting the Attorney General's concession that "necessary" in the exception should be interpreted to mean a physician is permitted to perform a banned procedure "when the physician, in his or her own professional judgment, believes a partial-birth abortion is necessary to save a woman's life"). As this Court has held, the lack of a mens rea requirement in an abortion statute only "exacerbates the uncertainty of the statute." *Colautti*, 439 U.S. at 401.

[6] The Court in *Vuitch* went on to note that "[p]lacing such a burden of proof on a doctor would be peculiarly inconsistent with society's notions of the responsibility of the medical profession. Generally, doctors are encouraged by society's expectations, by the strictures of malpractice law and by their own professional standards to give their patients such treatment as is necessary to preserve their health." 402 U.S. at 71. Similarly, it is traditionally the role of prosecutors to ensure that doctors are acting in the best interests of their patients' health. The Federal

patient's "right to receive medical care in accordance with her licensed physician's best judgment and the physician's right to administer it" are no less important in the abortion context. *Bolton*, 410 U.S. at 197; *see also Planned Parenthood of Se. Pa.* v. *Casey*, 505 U.S. 833, 884 (1992).[7]

The Federal Abortion Ban impermissibly requires prosecutors to substitute their judgment for that of physicians, a role prosecutors generally do not play. As the Government elsewhere has recognized, "[m]edical professionals, not lawyers, are the key to quality care." U.S. Dep't Health & Human Servs., *Addressing the New Health Care Crisis: Reforming the Medical Litigation System To Improve the Quality of Health Care* 29 (2003). Indeed, the Ban not only would have prosecutors interfere with the relationship between a doctor and her patient, but it would have prosecutors *replace* physicians' judgments with their own. Prosecutors simply are not equipped—nor should they be expected—to make medical judgments. Empowering prosecutors to do so is particularly dangerous here, where the vague proscriptions of the statute permit discriminatory enforcement in a highly politicized environment. To best protect the public health, reliance must be placed in the licensed physician's medical judgment, and not in the prosecutor. *Dent* v. *State of W. Va.*, 129 U.S. 114, 122-23 (1889); *see also Bolton*, 410 U.S. at 200.

Abortion Ban, however, requires prosecutors to enforce a law that imposes criminal penalties on a doctor who performs the banned procedures when, in her best medical judgment, she believes it is necessary to protect her patient's health. Neither prosecutors nor physicians should be put in such an untenable position.

[7] This Court in *Casey* reaffirmed that the doctor-patient relationship is entitled to the same solicitude in the abortion context as in other contexts. *Casey*, 505 U.S. at 884.

C. The Federal Abortion Ban Undermines the Necessary Public Perception of the Fairness of the Criminal Justice System

It is a bedrock principle that for the criminal justice system to maintain its credibility the public must correctly perceive that prosecutors, jurors, and courts are independent, neutral actors and outside of politics. Yet, the Ban threatens this very principle amid a highly politicized environment.

1. Vague Laws Threaten the Well-Established Principle That Prosecutors Must Be Perceived as Independent

It is beyond question that prosecutors have an affirmative duty to act independently of politics or other factors.[8] Of equal importance is the public's perception of the prosecutor as an independent and unbiased actor in the criminal justice system. As stated in *Gentile* v. *State Bar of Nevada*, "[o]ur system grants prosecutors vast discretion at all stages of the criminal process," and, therefore, "[t]he public has an interest in its responsible exercise." 501 U.S. 1030, 1036 (1991) (citing *Morrison* v. *Olson*, 487 U.S. 654, 727-28 (1988)). Courts widely have noted that the public confidence in the neutrality and impartiality in the criminal justice system is crucial to the proper functioning of the system. *See, e.g.*, *Georgia* v. *McCollum*, 505 U.S. 42, 49 (1992) (stating that a prosecutor's discrimination undermines the public confidence in adjudication); *Lockhart* v. *McCree*, 476 U.S. 162, 174-75

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[8] *See Forrester* v. *White*, 484 U.S. at 223 ("objective and independent criteria . . . should guide [a prosecutor's] conduct"); *Malley* v. *Briggs*, 475 U.S. at 343 (stating that prosecutors should exercise "independent judgment"); *Burns* v. *Reed*, 500 U.S. 478, 485 (1991) ("[i]ndependence of judgment is required of prosecutors by the 'public trust'").

(1986) (recognizing that there is an important interest in "preserving 'public confidence in the fairness of the criminal justice system.'") (quoting *Taylor* v. *Louisiana*, 419 U.S. 522, 530-31 (1975)). *See also Holland* v. *Illinois*, 493 U.S. 474, 495 (1990) (upholding policies regarding the fair selection of juries in order to preserve public confidence in the impartiality of the criminal justice system) (quoting *Lockhart*, 476 U.S. at 174-75).

The Federal Abortion Ban—which neither provides warning to the public, nor clear direction to the prosecutor—creates the unmistakable presumption on behalf of the public that the prosecutor enforcing the law may be acting in an arbitrary or discriminatory manner. *See Kolender* v. *Lawson*, 461 U.S. 352, 358 (1983) ("Where the legislature fails to provide such minimal guidelines, a criminal statute may permit 'a standardless sweep [that] allows policemen, prosecutors, and juries to pursue their personal predilections.'") (quoting *Smith* v. *Goguen*, 415 U.S. 566, 575 (1974)). Because the Ban is subject to varying interpretations, and arose in a highly politicized environment, it creates this perception that it will be arbitrarily enforced. As a result, were the Ban to be upheld, the public's confidence in the independence of prosecutors will only be undermined, thereby jeopardizing the public's confidence in the system. Such a result is untenable.

2. The Politicized Nature of the Abortion Debate and This Ban in Particular Further Undermines the Perception of Prosecutors as Independent and Chills Doctors From Acting in the Best Interests of Their Patients

It is of particular importance to prosecutors that laws dealing with politically charged topics do not create the perception by the public that political inclinations, as opposed to justice, motivate the enforcement of the law. Laws created

amidst a melee of political crossfire in particular require specificity, which the Ban utterly lacks.

This Court has recognized that arbitrary enforcement of a statute, or the *perception* thereof, is particularly problematic when emotions run high or participants feel strongly about a controversial matter, *see Cox* v. *Louisiana*, 379 U.S. 536, 551, 557 (1965) (holding, in a racial protest case, that a vague and overbroad Louisiana breach of peace statute "would allow persons to be punished merely for peacefully expressing unpopular views"),[9] and also that the independence and neutrality of prosecutors are threatened when they are asked to enforce vague criminal laws regarding political issues. *See, e.g.*, *Smith*, 415 U.S. at 575 ("Statutory language of such a standardless sweep [in a flag misuse statute] allows policemen, prosecutors, and juries to pursue their personal predilections."); *Papachristou* v. *City of Jacksonville*, 405 U.S. 156, 170 (1972) (holding that an unconstitutionally vague ordinance "furnishes a convenient tool for harsh and discriminatory enforcement by local prosecuting officials, against particular groups deemed to merit their displeasure") (internal quotations omitted).

It is undeniable that abortion is a highly controversial political issue. Indeed, "[t]he issue of abortion is one of the most contentious and controversial in contemporary American society." *Stenberg*, 530 U.S. at 947 (O'Connor, J., concurring). Accordingly, courts widely have recognized the particular dangers of vague and overbroad abortion laws. *See, e.g.*,

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[9] *See also Police Dept. of Chicago* v. *Mosley*, 408 U.S. 92, 96 (1972) ("government may not grant the use of a forum to people whose views it finds acceptable, but deny use to those wishing to express less favored or more controversial views") (quoted in *Denver Area Educ. Telcomms. Consortium* v. *FCC*, 518 U.S. 727, 799 (1996) (Kennedy, J., concurring in part, concurring in the judgment in part, and dissenting in part)).

Women's Med. Ctr. of N.W. Houston v. *Bell*, 248 F.3d 411, 422 (5th Cir. 2001) ("Especially in the context of abortion, a constitutionally protected right that has been a traditional target of hostility, standardless laws and regulations such as these open the door to potentially arbitrary and discriminatory enforcement."); *Tucson Women's Clinic* v. *Eden*, 371 F.3d 1173, 1196 (9th Cir. 2004). In fact, courts to have considered the Federal Abortion Ban aptly have noted the highly politicized environment surrounding this law in particular.[10]

Highlighting the political nature of this statute is the fact that the Ban is unlike any other law in existence. *Amici* can find no other law in the United States Code that criminalizes a surgical procedure performed by a doctor and simultaneously lacks a health exception. The only other federal statute that even regulates a medical procedure is the Female Genital Mutilation Ban statute ("FGM statute"), 18 U.S.C. § 116 (1996), and that statute contains a health exception.[11] Moreover, the

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[10] The district court below noted that "[d]issenting legislators within Congress made the same observations" as many testifying physicians, that "the term 'partial-birth abortion' has little if any medical significance in and of itself" and "is a term invented for political purposes." *Planned Parenthood Fed'n of Am.* v. *Ashcroft*, 320 F. Supp. 2d at 977. The court of appeals later observed that many sponsors of the Act expressed the sentiment that a "partial victory [would be] worthless from a political standpoint" and that they would rather have no statute than a statute with a health exception. *Planned Parenthood Fed'n of Am., Inc.* v. *Gonzales*, 435 F.3d at 1187. The court further noted that the supporters of the bill were "congressional partisans" and that "[a]bortion is an issue that causes partisans on both sides to invoke strongly held fundamental principles and beliefs." *Id.*

[11] The FGM statute states that "whoever knowingly circumcises, excises, or infibulates [the genitals of a female] . . . shall be fined under this title or imprisoned not more than 5 years, or both." 18 U.S.C. § 116. A "surgical operation" would not violate the statute if it were "necessary to the health of the person on whom it is performed." *Id.*

Federal Abortion Ban serves neither state interest outlined by this Court in *Casey*. As stated in *Casey*, abortion regulations potentially serve "two relevant state interests: 'an interest in preserving and protecting the health of the pregnant woman' and an interest in 'protecting the potentiality of human life.'" *Casey*, 505 U.S. at 929 (quoting *Roe* v. *Wade*, 410 U.S. 113, 162 (1973)). The Ban, however, neglects the first state interest of protecting a woman's health because it lacks a health exception. And, like the Nebraska Abortion Ban struck down in *Stenberg*, the Federal Ban "does not directly further an interest 'in the potentiality of human life' by saving the fetus in question from destruction, as it regulates only a *method* of performing abortion." *Stenberg*, 530 U.S. at 930 (emphasis added).

Because the debate surrounding abortion has been politically charged, specificity in the statutory text is particularly important. The Ban lacks such specificity. Without it, prosecutors will suffer from the misperception that any effort to enforce the law, or not, is a politically motivated, biased act. For these reasons, the decision of the court of appeals below should be affirmed.

II.
THE FEDERAL ABORTION BAN ALSO IS UNCONSTITUTIONALLY OVERBROAD, FURTHER THREATENING THE INTEGRITY OF THE CRIMINAL JUSTICE SYSTEM

In addition to being unconstitutionally vague, the Federal Abortion Ban is overbroad because it includes within its scope protected activities. *See Nat'l Ass'n for the Advancement of Colored People* v. *Alabama ex rel. Flowers*, 377 U.S. 288, 308-09 (1964). While even "[a] clear and precise enactment may . . . be 'overbroad' if in its reach it prohibits constitutionally protected conduct," *Grayned*, 408 U.S. at 114,

statutes that are vague increase the likelihood of overbreadth, *Vill. of Hoffman Estates* v. *Flipside, Hoffman Estates, Inc.*, 455 U.S. 489, 495 n.6 (1982) ("[T]he vagueness of a law affects overbreadth analysis."). The Federal Abortion Ban suffers from this very overbreadth.[12]

A. The Federal Abortion Ban Is Unconstitutionally Overbroad Because it Criminalizes a Majority of Second Trimester Pre-Viability Abortion Procedures

Under this Court's precedent, a woman has a constitutional right to choose to terminate a previability pregnancy and neither the state nor Congress may impose an "undue burden" on that right. Laws that threaten this right and impose criminal and/or civil liability are overbroad and constitutionally impermissible. *See, e.g., Stenberg*, 530 U.S. at 938-46.

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[12] The Government erroneously contends that the "only way to reconcile" the court of appeals' finding that the Ban is both vague and overbroad is to conclude that the court "flouted its normal obligation" to construe the statute narrowly. (Pet. Br. at 37.) This Court has held on numerous occasions that statutes may be both vague and overbroad, *see, e.g., Gooding* v. *Wilson*, 405 U.S. 518, 519-20 (1972) (affirming district court holding that statute was vague and overbroad), and has in fact held that statutes that are vague are more likely to be susceptible to an overbreadth challenge, *Hoffman Estates*, 455 U.S. at 495 n.6 ("The Court has long recognized that ambiguous meanings cause citizens to steer far wider of the lawful zone . . . than if the boundaries of the forbidden areas were clearly marked") (internal quotations omitted). In this case in particular, the vagueness in the statute only contributes to its overbreadth. Since it is impossible to determine whether Congress' findings relating to the alleged health effects of the prohibited conduct actually apply to all of the conduct criminalized under the Federal Abortion Ban, the statute necessarily fails under *Stenberg* for lack of a health exception and is unconstitutionally overbroad.

This Court has already determined that laws seeking to ban abortion procedures without a health exception are unconstitutionally overbroad. There is no reason for the Court to revisit this precedent.[13] In *Stenberg*, the Court reaffirmed *Casey*, holding that a statute with the "purpose or effect" of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus is an undue burden. *Id.* at 921 (quoting *Casey*, 505 U.S. at 877). After analyzing Nebraska's "partial-birth abortion" ban, the Court in *Stenberg* found the ban unconstitutional because it applied to a broader range of procedures than intact D&E, and would, in practice, prohibit most second trimester abortions. *Stenberg*, 530 U.S. at 939. Specifically, Nebraska's ban did not "track the medical differences between D&E and D&X—though it would have been a simple matter, for example, to provide an exception for the performance of D&E and other abortion procedures." *Id.* Similarly, Nebraska's ban failed to distinguish between D&E procedures involving an intact versus a disarticulated fetus. *Id.* Concluding that the ban left doctors who perform constitutionally protected D&E procedures subject to a legitimate "fear [of] prosecution, conviction, and imprisonment," this Court found the ban unconstitutional. *Id.* at 945.

The Federal Abortion Ban suffers from the exact same overbreadth as was at issue in *Stenberg*. The Ninth Circuit correctly affirmed the district court's finding that "the Act's definition of 'partial-birth abortion' reached all D&E procedures

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[13] Indeed, *stare decisis* "commands judicial respect for . . . earlier decisions." *Randall* v. *Sorrell*, 126 S.Ct. 2479, 2498 (2006). As this Court has held, "the rule of law demands that adhereing to . . . prior case law be the norm. Departure from precedent is exceptional, and requires 'special justification.'" *Id.* (quoting *Arizona* v. *Rumsey*, 467 U.S. 203, 212 (1984)).

as well as certain induction abortions" and that "the Act created a risk of criminal liability for virtually all abortions performed after the first trimester." *Planned Parenthood Fed'n of Am.* v. *Gonzales*, 435 F.3d at 1169; *see Planned Parenthood Fed'n of Am.* v. *Ashcroft*, 320 F. Supp. 2d at 973-74; *Carhart* v. *Ashcroft*, 331 F. Supp. 2d 805, 1031 (D. Neb. 2004).[14] As the court of appeals below, and every other court to consider the issue, has found, the Federal Abortion Ban, like the abortion ban in *Stenberg*, prohibits most second trimester abortions, and may also encompasses non-abortion medical procedures. *Planned Parenthood Fed'n of Am.* v. *Gonzales*, 435 F.3d at 1169, 1177; *Carhart* v. *Ashcroft*, 331 F. Supp. 2d at 1031; *Planned Parenthood Fed'n of Am.* v. *Ashcroft*, 320 F. Supp. 2d 957, 973-74 (N.D. Cal. 2004). It, accordingly, is unconstitutional.

The Ban's overbreadth is indeed substantial. As discussed above, the term "partial-birth abortion" is not a medically-recognized term and does not limit the scope of the Ban. *Planned Parenthood Fed'n of Am.* v. *Gonzales*, 435 F.3d at 1181; *Farmer*, 220 F.3d at 136; *Miller*, 30 F. Supp. 2d at 1165. And Congress' attempt at definition "could readily be applied to a range of methods of performing post-first trimester abortions." *Planned Parenthood Fed'n of Am.*, 435 F.3d at 1183.

The Government attempts to save the statute by arguing that the "overt act" requirement somehow limits the statute's

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[14] Because of the Ban's overbroad sweep, Congress' findings regarding the safety of the specific procedures that were intended to be criminalized by the Federal Abortion Ban do not apply to all of the procedures proscribed by the Ban. *See* Partial-Birth Abortion Ban Act of 2003, Pub. L. No. 108-105, § 2(14), 117 Stat. 1201, 1204-06 (2003). Whatever the merits of Congress' findings, they do not apply to non-intact D&Es or to induction abortions, which also are criminalized by the Ban.

scope to intact D&E procedures. Not so. As noted above, the term "overt act" may encompass any number of procedures utilized in D&E procedures, inductions, and treatment of miscarriages. *See* IB *supra.* Indeed, the Government itself *concedes* that the term is *purposefully* broad. (Pet. Br. at 38.) Congress rejected during the debates any attempt to limit the Ban's scope to intact D&E and D&X.[15] Simply put, Congress cast too broad a net, outlawing procedures routinely used in more than 85% of post-first trimester abortions. *See Planned Parenthood Fed'n of Am.* v. *Gonzales*, 435 F.3d at 1166. For these reasons too, the Ban is unconstitutionally overbroad.[16]

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[15] As this Court held in *Stenberg*, "it would have been a simple matter . . . to provide an exception for the performance of D&E and other abortion procedures" or to use language tracking the medical differences between intact and non-intact D&Es. 530 U.S. 914, 939 (2000). In fact, the *Stenberg* Court set forth specific guidelines on how a legislature could distinguish intact D&E. Congress purposefully declined to heed this Court's advice and rejected amendments to narrow the statute's scope. *See Planned Parenthood Fed'n of Am.* v. *Ashcroft*, 320 F. Supp. 2d at 974. Instead, Congress drafted a statute that criminalizes a large majority of second trimester abortion procedures and thus encroaches on a woman's constitutional right to choose to have a previability abortion.

[16] The absence of any scienter element in the life exception further underscores the Ban's unconstitutional overbreadth. This Court repeatedly has insisted that life and health exceptions triggered by a necessity requirement must be made in the physician's "appropriate medical judgment." *Stenberg*, 530 U.S. at 937; *Casey*, 505 U.S. at 879; *see also Colautti*, 439 U.S. at 401. Here, however, the Ban's life exception is both overly narrow and vague. When coupled with the absence of a health exception, the effect of the statute is to place an undue burden on a woman's rights and, therefore, is unconstitutional.

B. Because the Federal Abortion Ban Is Vague and Overbroad, It Undermines the Traditional Role of Prosecutors to Enforce Laws That Protect the Health and Safety of the Public

It goes without saying that vague and overbroad laws chill constitutionally protected conduct. This chilling effect is particularly problematic, where, as here, the constitutionally protected conduct that the statute chills may be necessary to protect the health of a woman.

For prosecutors, this is troublesome for several reasons. First, the Ban contradicts the well settled role of prosecutors of protecting the public health by putting them in a position of chilling doctors' conduct. Second, it conflicts with the traditional role of prosecutors by forcing them to prosecute doctors who act in the best interests of their patients. When prosecutors are acting *against* the interests of patient health and seek to enforce a statute that permits arbitrary and discriminatory application, the public no doubt will construe a prosecutor's actions as politically motivated. This result undermines the entire criminal justice system and is simply untenable.

1. The Federal Abortion Ban Will Create a "Chilling Effect"

As noted, the substantial vagueness and overbreadth of the Federal Abortion Ban chills constitutionally protected activities. The Ban prohibits "nearly 85-95% of all second trimester abortions." *Planned Parenthood Fed'n of Am.* v. *Ashcroft*, 320 F. Supp. 2d at 974. Because of this overbreadth, the Federal Abortion Ban chills protected conduct, leading physicians to avoid performing medically necessary abortion procedures because they fear prosecution and imprisonment.

See Stenberg, 530 U.S. at 945-46 (noting that under an overbroad abortion ban, "[a]ll those who perform abortion procedures involving [the D&E] method must fear prosecution, conviction, and imprisonment").

The Ban's vagueness exacerbates this chilling effect. As explained, the vague proscriptions set forth in the Ban leave physicians in doubt of what is required of them to conform their conduct to the law. *See Carhart* v. *Ashcroft*, 331 F. Supp. 2d at 1032 ("Physician after physician expressed sincere doubt about how far the ban extended."); IA *supra*. Courts have noted that vague laws that impose civil liability on physicians for performing abortion procedures lead physicians to "steer far wider of the unlawful zone" than if the statutes were more precise in their scope. *Hoffman Estates*, 455 U.S. at 495 n.6.

The *criminal* liability established by the Federal Abortion Ban will have—and, in fact, has already begun to have—still more pronounced chilling effects. *See, e.g.*, *Planned Parenthood Fed'n of Am.* v. *Ashcroft*, 320 F. Supp. 2d at 974. Indeed, "[a] majority of the physicians who testified noted that because they fear prosecution, conviction, and imprisonment, the wide net cast by the Act could have and has already had the effect of impacting all previability second trimester abortion services that they provide to their patients." *Planned Parenthood Fed'n of Am.* v. *Ashcroft*, 320 F. Supp. 2d at 974 (internal quotations omitted); *see also Planned Parenthood Fed'n of Am.* v. *Gonzales*, 435 F.3d at 1179 (noting the "chilling effect on doctors' willingness to perform previability post-first trimester abortions").

The chilling of doctors who perform abortions harms not only women seeking abortions, but all women in need of reproductive health care.

2. Enforcing the Federal Abortion Ban Is Contrary to the Well-Settled Role of Prosecutors in Enforcing Laws to Protect the Health and Safety of Citizens

"[T]his Court has made clear that a State may promote but not endanger a woman's health when it regulates the methods of abortion." *Stenberg*, 530 U.S. at 931 (citing *Thornburgh* v. *Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747 768-69 (1986)); *Colautti*, 439 U.S. at 400; *Planned Parenthood of Cent. Missouri* v. *Danforth*, 428 U.S. 52, 76-79 (1976); *Bolton*, 410 U.S. at 197; *see also Casey*, 505 U.S. at 879 (holding that the state may not proscribe abortion "'where it is necessary, in appropriate medical judgment, for the preservation of the life *or health* of the mother'") (quoting *Roe*, 410 U.S. at 164-65 (emphasis added)).

Though numerous Senators and Representatives warned that the Federal Abortion Ban would be unconstitutional without a health exception, Congress deliberately chose not to include such an exception. *See Planned Parenthood Fed'n of Am.* v. *Gonzales*, 435 F.3d at 1185-86 & nn.26-28. As every court to consider the Ban has found, substantial medical authority supports the proposition that prohibiting intact D&Es could endanger women's health. *Nat'l Abortion Fed'n* v. *Gonzales*, 437 F.3d 278, 285 (2d Cir. 2006); *Planned Parenthood Fed'n of Am.* v. *Gonzales*, 435 F.3d at 1174-76; *Carhart* v. *Gonzales*, 413 F.3d 791, 802 (8th Cir. 2005); *Carhart* v. *Ashcroft*, 331 F. Supp. 2d at 1017; *Nat'l Abortion Fed'n* v. *Ashcroft*, 330 F. Supp. 2d 436, 489 (S.D.N.Y. 2004); *Planned Parenthood Fed'n of Am.* v. *Ashcroft*, 320 F. Supp. 2d at 1033; *see also Stenberg*, 530 U.S. at 932 ("[S]ignificant medical authority supports the proposition that in some circumstances, D&X would be the safest procedure."); *id.* at 937 ("[U]ncertainty means a significant likelihood that those who believe that D&X is a safer abortion

method in certain circumstances may turn out to be right. If so, then the absence of a health exception will place women at an unnecessary risk of tragic health consequences."). Indeed, doctors testified below that intact D&E may in fact be the *best practice* for many physicians. *Planned Parenthood Fed'n of America* v. *Gonzales*, 320 F. Supp. 2d at 1001.

Because the Ban does not contain a health exception, it prohibits doctors from performing a medical procedure that they may believe in good faith is necessary to preserve the health of their patients.[17] Enforcing this Ban—and prosecuting a physician for acting to safeguard the health of her patient—would contradict the professional obligations of prosecutors dedicated to protecting the public health and welfare. As a result, doctors and women undoubtedly will fear that "overly zealous prosecutors [would be] emboldened to take improper advantage." *Carhart* v. *Ashcroft*, 331 F. Supp. 2d at 1040. Thus, the mere threat of prosecution erodes both women's reproductive rights and the valued role of prosecutors as neutral and independent law-enforcers. The danger of such a result is obvious.

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[17] This brief does not address whether deference is due Congress' "findings." Quite simply, the Ban prohibits a doctor from performing a procedure that could preserve the health of her patient. If, as Congress found, the Ban were never necessary to preserve the health of a patient, there would be no harm in including an exception for the potential circumstance where that were the case. On the other hand, if Congress' "findings" are wrong, and the prohibited procedures are necessary to preserve a woman's health, enforcing this Ban endangers that woman's health.

CONCLUSION

For the foregoing reasons, *Amici* respectfully submit that the Court should affirm the decisions below.

Dated: September 20, 2006

Respectfully submitted,

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No. 05-1382 & No. 05-380

In The
Supreme Court of the United States

ALBERTO R. GONZALES, ATTORNEY GENERAL,

Petitioner,

v.

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., *et al.*,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

ALBERTO R. GONZALES, ATTORNEY GENERAL,

Petitioner,

v.

LEROY CARHART, M.D., *et al.*,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

BRIEF OF THE INSTITUTE FOR REPRODUCTIVE HEALTH ACCESS AND FIFTY-TWO CLINICS AND ORGANIZATIONS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS IN *GONZALES V. PLANNED PARENTHOOD FEDERATION OF AMERICA, ET AL.*, NO. 05-1382, AND MOTION FOR LEAVE TO FILE BRIEF OUT OF TIME IN SUPPORT OF RESPONDENTS IN *GONZALES V. CARHART, ET AL.*, NO. 05-380

Dated: September 20, 2006

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MOTION FOR LEAVE TO FILE OUT OF TIME BRIEF *AMICI CURIAE* IN SUPPORT OF RESPONDENTS IN RELATED CASE, *GONZALES V. CARHART, ET AL.*

The Institute for Reproductive Health Access and fifty-two additional clinics and organizations (*see* Appendix) that work with and/or on behalf of women seeking second-trimester abortions, respectfully move this Court to grant them leave to file the attached brief as *amici curiae* in *Gonzales v. Carhart, et al.*, No. 05-380.

All of the parties have consented to the filing of the attached brief in support of the Respondents in both *Gonzales v. Planned Parenthood Federation of America, et al.*, 05-1382, and *Gonzales v. Carhart, et al.*, 05-380. Those letters of consent have been submitted to this Court.

The above-captioned case and *Gonzales v. Carhart* are related, and both raise identical constitutional issues regarding the Federal Abortion Ban. *See* Partial-Birth Abortion Ban Act of 2003, Pub. L. No. 108-105, 117 Stat. 1201 (codified at 18 U.S.C. § 1531). Both cases are scheduled to be heard by the Court on the same day, and the parties in both cases have all consented to the participation of *amicus curiae* in the *Gonzales v. Carhart* case.

Amici curiae were originally scheduled to file the attached brief in support of Respondents in both cases on August 10, 2006. *Amici curiae* were advised that the Clerk's Office of this Court, however, would consider briefs to be timely filed in both cases if submitted by the date of filing in *Gonzales v. Planned Parenthood Federation of America*. *See* Exh. A. *Amici curiae* relied upon the Clerk's Office statement, and did not file its brief on August 10, 2006. It is our understanding that the Clerk's Office has

subsequently advised that leave of this Court will be required in order for the attached brief to be considered timely in *Carhart*.

Petitioner will not be prejudiced by this Court granting leave to *amici curiae* in *Carhart*, and the information and arguments presented in the brief submitted by *amici curiae* are equally relevant to both cases.

Accordingly, *amici curiae* request that the Court grant them leave to file a jointly-captioned brief in support of Respondents in both cases, and direct the Clerk to accept this brief out-of-time in *Gonzales v. Carhart*, No. 05-380 and to docket the brief in accord with the foregoing.

Dated: September 20, 2006

Respectfully submitted,

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**CENTER
FOR
REPRODUCTIVE
RIGHTS**

BY FACSIMILE AND OVERNIGHT MAIL

August 4, 2006

Denise McNerney
Office of the Clerk
1 First Street, N.E.
Washington, D.C. 20543

Re: *Gonzales v. Carhart*, No. 05-380

Dear Ms. McNerney,

Thank you for discussing the briefing schedule for amici in the above-captioned case. This is to confirm that, as we discussed, amici filing in support of Respondents in *Gonzales v. Carhart*, No. 05-380, may file their briefs on the date that amicus briefs are due in support of Respondents in *Gonzales v. Planned Parenthood Federation of America Inc.*, No. 05-1382 under the captions for both cases.

Sincerely,

/s/ Priscilla J. Smith
Counsel for Respondents

cc: Eve Gartner
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EXHIBIT A

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INTEREST OF *AMICI CURIAE*[1]

Amici Curiae are fifty-three clinics and organizations that work with and/or on behalf of women seeking second-trimester abortions. This Brief is submitted to provide the Court with accounts of individual women who obtained abortions in their second-trimester of pregnancy. As organizations that hear first-hand about the impact abortion has in women's lives, *Amici* have an interest in the future of access to second-trimester abortions threatened by the Federal Abortion Ban. Individual *Amici* statements of interest are contained in the Appendix to this Brief. *See* Appendix.

SUMMARY OF ARGUMENT

Abortion is one of the most intimate and personal acts subject to consideration by Congress and this Court. In the more than thirty years since *Roe v. Wade*, 410 U.S. 113 (1973), the reasons individual women seek abortions in the second trimester have been overshadowed by the politics and rhetoric of "pro-choice" and "pro-life." It is essential therefore for this Court to consider the individual women whose lives and liberty may be impacted by a ban on any – let alone all – safe second-trimester abortion procedures.

In this Brief, *Amici* excerpt testimonials from over 150 women who shared their stories of second-trimester abortions. The women hail from across the country, and

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[1] Counsel drafted this Brief with the advice and consent of *Amici*, and all of the parties have consented to the filing of this Brief in *Gonzales v. Planned Parenthood Federation of America, et al.*, No. 05-1382 and *Gonzales v. Carhart, et al.*, No. 05-380. Consistent with Supreme Court Rule 37.6, this Brief was not authored in whole or in part by counsel for any party. No person, other than *Amici* or their counsel, has made a monetary contribution for the preparation or submission of this Brief.

they are from diverse racial, religious and socio-economic backgrounds. Their experiences are remarkably similar, however, and reveal that individual women find themselves facing second-trimester abortions primarily when: (1) they are carrying wanted pregnancies in which the fetus is diagnosed with grave anomalies; (2) their own health becomes endangered by their pregnancy; or (3) they have been unable to access care because of financial, geographic, or other delays. Their stories also demonstrate that, in each of these circumstances, women consistently consider abortion for moral reasons that are fundamental to their religious, personal, and family values.

ARGUMENT

I. *Amici* Collected Accounts of More than 150 Women Who Had Second-Trimester Abortions.

The Federal Abortion Ban prohibits at least one safe second-trimester abortion procedure[2] with no exception to preserve a woman's health.[3] *See* Partial-Birth Abortion Ban Act of 2003, Pub. L. No. 108-105, 117 Stat. 1201

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[2] The second trimester of pregnancy is generally regarded as beginning at twelve to fourteen weeks, determined as a function of gestational age or "last menstrual period" dating. *See, e.g., Stenberg v. Carhart*, 530 U.S. 914, 923 (2000).

[3] The Attorney General acknowledges that the Federal Abortion Ban prohibits the "dilation and extraction" method of abortion. *See, e.g.*, Br. of Pet'r at 2-3; 18 U.S.C. § 1531, Pub. L. No. 108-105 (2003) (Congressional findings). There are three primary methods of abortions in the second trimester: dilation and evacuation (D&E); dilation and extraction (D&X); and induction. *See Carhart v. Gonzales*, 413 F.3d 791, 793-94 (8th Cir. 2005). D&X is a variant of the D&E procedure and the terms "dilation and extraction," "D&X" and "intact D&E" are used interchangeably. *Stenberg*, 530 U.S. at 928 (2000). Ninety-five percent of second-trimester abortions are performed before 20 weeks' gestation and prior to fetal viability, notwithstanding that they are sometimes deemed "late term." *See Stenberg*, 530 U.S. at 924.

(codified at 18 U.S.C. § 1531) (hereinafter the "Federal Abortion Ban" or "Ban"); *see also Planned Parenthood Fed'n of America, Inc. v. Gonzales*, 435 F.3d 1163 (9th Cir. 2006); *Carhart v. Gonzales*, 413 F.3d 791 (8th Cir. 2005). In attempting to proscribe second-trimester abortions, Congress and the Attorney General focus on the Government's interest in legislating the morality of abortion without any meaningful regard to the concerns of the individual women who seek those procedures.

In this Brief, *Amici* present the stories of women who have had second-trimester abortions.[4] Excerpted below are testimonials culled from more than 150 interviews, letters, and e-mails provided by women specifically to support the right to safe second-trimester abortion threatened by the Federal Abortion Ban. In order to find women willing to tell their stories, The Institute for Reproductive Health Access (the "Institute") contacted abortion clinics across the country and provided them with fliers to distribute to women. The fliers advised women they could send an e-mail or telephone a toll-free number to tell their stories about second-trimester abortions.

Abortion clinics across the country also permitted the Institute, as well as attorneys from the domestic offices of Orrick, Herrington & Sutcliffe LLP ("Orrick"), to conduct on-site interviews of women willing to tell their stories for this *Amicus* Brief. Women were also advised they could submit their stories by letter.[5]

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[4] The majority of the women who came forward to share their experiences had second-trimester abortions in the last six months and during the pendency of the underlying litigation in this case. Several women submitted stories of abortions performed more than ten years ago and we have noted those stories when cited.

[5] In addition to canvassing the country to find women willing to come forward to tell their stories for this Brief, the Institute approached groups that routinely gather women's accounts of why they obtain

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It is not easy for women to come forward and speak about their personal reasons for obtaining second-trimester abortions, let alone to share their stories in support of a public filing. Indeed, this Court has long recognized that women may be deterred from asserting their rights if they are required to make their abortion decisions public. Accordingly, the Court has permitted women to proceed as plaintiffs using pseudonyms, *see, e.g., Roe v. Wade*, 410 U.S. at 124; *Doe v. Bolton*, 410 U.S. 179, 187 (1973), and has held that physicians have standing to assert the interests of their patients, in part, because a woman may be deterred from asserting her own rights "by a desire to protect the very privacy of her decision from the publicity of a court suit." *Singleton v. Wulff*, 428 U.S. 106, 117 (1976) (opinion of Blackmun, J.).

To ensure the privacy and safety of the individual women who submitted stories, we refer to them herein by first name only, although many authorized us to use their full names. For those women who requested we not use their real names, we identify them solely as "Jane Doe," and when possible we describe the regions of the country from which women shared their stories.

The testimonials collected for this Brief are not sworn testimony or record evidence, but they are a unique source of insight into the circumstances and lives of individual women who chose to have second-trimester abortions. The Court has routinely accepted similar testimonials in the past. *See, e.g., Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 749 (1986) (referencing brief filed by NARAL); *see*

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second-trimester procedures. For example, the Institute approached organizations that provide funds to women who cannot afford to pay for abortion services. A number of funds shared their collected stories, provided counsel did not use any identifying information about the individual women, and we have honored that request.

also Harris v. U.S., 536 U.S. 545, 568 (2002) (citing *amicus* brief excerpting letters from sentencing judges). The women did not receive any remuneration for sharing their stories, and all of the letters, e-mails, and taped interviews collected for this Brief are on file in Orrick's New York office.[6]

It is worth noting that no individual woman's story is repeated in the Brief; each woman is quoted only once. Moreover, although the Institute received a significant number of testimonials, each story is in itself significant. Each woman's story demonstrates how the right to abortion is singularly fundamental to the personal liberty of each and every woman who chooses to exercise it.

II. Women Seek Second-Trimester Abortions For Three Primary Reasons.

At current rates, one in three American women will have an abortion by age 45.[7] The majority of induced abortions in this country take place in the first trimester of pregnancy; nevertheless second-trimester abortions are not uncommon.[8]

Women who have second-trimester abortions are from different races, backgrounds, geographic regions, and

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[6] The women's submissions have been compiled into two bound volumes also on file with Orrick, and it is to these volumes that the citations below refer.

[7] *See* Stanley K. Henshaw, *Unintended Pregnancy in the U.S.*, FAM. PLAN. PERSP., Jan.-Feb. 1998, at 28.

[8] In 2002 the Centers for Disease Control and Prevention (CDC) estimated that 87% of abortions were performed during the first trimester. *See* Lilo T. Strauss, *et al.*, *Abortion Surveillance: U.S. 2002*, MORBIDITY & MORTALITY WKLY. REP., Nov. 2005, at 1-31, *avail. at* www.cdc.gov/mmwr/preview/mmwrhtml/ss5407a1.htm. Between 9-10% of abortions from 1990 to 2001 took place in the second trimester. *See* U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE U.S. (123d ed. 2004), *avail. at* www.census.gov/compendia/statab/vital_statistics/family_planning_abortions/.

religious faiths.[9] Of the women who provided accounts, approximately 30 percent obtained second-trimester procedures after their pregnancies were diagnosed with severe fetal anomalies. Less than five percent obtained procedures when their own health became imperiled by their pregnancies; and approximately 55 percent obtained second-trimester procedures for other reasons primarily because of delayed access to abortion services due to financial or geographic obstacles. As noted below, at least two of the women obtained abortions performed using the "dilation and extraction" method – the procedure Congress seeks to ban outright under the Federal Abortion Ban. *See, e.g.*, Br. of Pet'r at 2-3; 18 U.S.C. § 1531 (Congressional findings).[10]

A. Wanted Fetuses Diagnosed with Grave Anomalies in the Second Trimester.

One of the tragic realities of second-trimester abortions is that many women who obtain them are carrying pregnancies that were entirely wanted. As many of the women note, tests to assess whether certain grave conditions or disorders affect a pregnancy cannot be administered prior to the second trimester.[11] As a result, a woman whose fetus is critically

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[9] In their accounts, individual women self-identified as Baptist, Catholic, "conservative Christian," Jehovah's Witnesses, Jewish, Muslim, Presbyterian, atheist, and "spiritual." Individual women identified as members of different racial and ethnic groups, including African-American, Asian-American, Caucasian, and Latina. The women who submitted their stories are from more than half of the States, including, *inter alia*, Alaska, Arizona, California, Colorado, Connecticut, Florida, Georgia, Idaho, Illinois, Louisiana, Maryland, New York, New Jersey, Ohio, Oregon, Pennsylvania, Virginia, and Washington.

[10] While two of the women's stories make clear they obtained D&X procedures, some of the women's testimonials refer alternatively to having obtained a D&E and a D&X procedure, suggesting that more than two of the women who submitted stories may have obtained a D&X procedure.

[11] Amniocentesis is the most common and accurate prenatal test used to diagnose serious birth defects. It is generally not available before the

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impaired will often not learn that fact until well into the second trimester of her pregnancy. Often women learn, only for the first time in the second-trimester, of mortally serious conditions and disorders such as Trisomy 18 or Patau's syndrome;[12] Trisomy 18 or Edward's syndrome;[13] Cat Eye syndrome or chromosome 22 disorder;[14] congenital CMV;[15] or Turner Syndrome.[16]

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fifteentn week of pregnancy. "Chorionic villus sampling," or CVS, is a test available starting at ten to thirteen weeks in pregnancy but is useful to identify a limited subset of abnormalities identifiable by amniocentesis. *See* F. GARY CUNNINGHAM, *ET AL.*, WILLIAMS OBSTETRICS 329-30 (22d ed. 2005).

[12] Median survival rate for infants born with Trisomy 13 is seven days. Only 10% of infants with the chromosomal disorder will celebrate their first birthday. Eighty to 90% of infants with Trisomy 13 will suffer from cardiac defects, and 70% will suffer from a spectrum of significant cranio-facial malformations. *See* WILLIAMS, *supra* n.11, at 291; *see also* Support for the Trisomy 13, and Related Disorders, Trisomy 13 Facts, www.trisomy.org/html/trisomy_13_facts.htm (visited Aug. 9, 2006).

[13] Most infants born with Trisomy 18 die within fourteen days of birth and only 10% survive more than one year. Those who survive are profoundly retarded and 95% have cardiac defects. WILLIAMS, *supra* n.11, at 290; *see also* Support for the Trisomy 18, and Related Disorders, Trisomy 18 Facts, www.trisomy.org/html/trisomy_18_facts.htm (visited Aug. 9, 2006).

[14] Cat Eye syndrome typically results in the grotesque malformation of a fetus's skull and facial features. Additional conditions associated with the chromosomal disorder include malformations of the heart, kidneys, and intestinal and anal systems. *See* Nat'l Inst. of Health, Nat'l Library of Med., *avail. at* www.nlm.nih.gov/cgi/jablonski/syndrome_cgi?index=93 (visited Aug. 9, 2006); *see also* Nat'l Org. for Rare Disorders, Cat Eye Syndrome, *avail. at* www.rarediseases.org/search/rdb detail_abstract.html (visited Aug. 9, 2006).

[15] In 90% of infants born that show no symptoms of CMV at birth, 15% will develop one or more neurological abnormalities, usually in the first two years of life. Of the 10% that show symptoms at birth, up to 20% will die and about 90% of the survivors suffer from serious neurological defects. *See* WILLIAMS, *supra* n.11, at 1282-84; *see also* March of Dimes, Cytomegalovirus Infection in Pregnancy, *avail. at* www.marchofdimes.com/professionals/681_1195.asp (visited Aug. 9, 2006).

[16] The majority of fetuses with Turner Syndrome that survive until the second trimester have major cardiac malformations. It is also common for these fetuses to have "cystic hygromas" or sacs of fluid that

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As the women describe, not only are some of the initial diagnostic tests administered only in the second trimester, but confirmatory tests – essential to the woman making an informed decision – take additional time.

Erin, a 35-year-old woman from the West Coast, describes her life as "pretty 'apple pie'." She explained the timing involved in receiving a diagnosis for her pregnancy:

> In addition to the terrible news about the probability of the baby having a serious problem came another nasty surprise: We would not be able to confirm if there was a problem or make any decision about how to proceed for quite some time. . . .
>
> Waiting to get the amnio was one of the most stressful, heart-rending, agonizing times of my life. My belly was growing, and my pregnancy was no longer a private matter because of that. I wanted to be upbeat, but I was terrified. The more research I did on Trisomy 13 and 18, the more terrified I got. . . .
>
> The amnio date finally arrived in the middle of my 15th week of pregnancy. During the amnio, they discovered that I also had a complete placenta previa – a condition where the placenta implants over the cervix. They felt my case was unlikely to resolve itself, which meant I would be at risk for severe bleeding as the pregnancy progressed. . . . [W]e tried to remain hopeful that the amnio results would show that the baby at least didn't have a fatal trisomy. . . . But unfortunately, the amnio results came back confirming our baby

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form from the neck and may be the size of or larger than the fetal head. WILLIAMS, *supra* n.11, at 395. Less than 2% of fetuses with Turner Syndrome survive pregnancy. *See id.* at 291. Of those infants who survive, 98% will be infertile and some will have heart, kidney, and neurological problems. *See also* Nat'l Inst. of Health, Turner Unit, *avail. at* http://turners.nichd.nih.gov/ClinFrTables.html (visited Aug. 9, 2006).

> had trisomy 18. At this point I was 16 weeks along and had begun feeling the baby kick. It should have been sweet, but instead the kicks were torture. We were utterly crushed.

Erin, submitted by e-mail, May 11, 2006, at 62-63.

Cara, a married Catholic woman with an almost-three-year-old son, has "always dreamed of having a big family." She described the time it took to obtain information needed about her pregnancy:

> I was about 17 weeks pregnant at the time. . . . [T]hey scheduled us for our Level II ultrasound a few weeks early so they could look in more detail at the baby. . . .
>
> A few days [after the ultrasound], we received the news that would change our lives forever. Our son was infected with CMV (cytomegalovirus). This was the worst possible scenario (of the possibilities we were given). . . .
>
> Although I have always been pro-choice, I had winced at the thought of late-term abortions or "partial birth" abortions, thinking that it was just inhumane or irresponsible. Now I know differently. In my case, we were not able to confirm our diagnosis until 19 or 20 weeks gestation. I terminated at 22 weeks. . . . I was completely heartbroken. . . .

Cara, submitted by e-mail, May 11, 2006, at 42-43.[17]

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[17] Some of the women who submitted stories identify as "pro-choice," while others continue to identify as "pro-life." *See, e.g.*, Jane Doe, on-site clinic interview, June 23, 2006, at 292 ("I was pro-choice and I just felt that America as a democracy should give people the right to choose"); Jocelyn, telephone interview, May 25, 2006, at 168 ("I'm always pro-life," explaining decision to terminate pregnancy with severe fetal anomalies); *see also* Sara, submitted by letter, May 12, 2006, at 5 ("I once was against abortion until it came to the future of the family I already have.").

Carrie, a 40-year-old woman from the Southwest who was happily married for nine years when she became pregnant described the timing of her genetic testing and decision to end her pregnancy:

> On November 11, 2005, I elected to have [a] CVS test.... Then, the test results came in.... We knew chromosome 14 was incompatible with life, and chromosome 22 could mean Cat Eye Syndrome. Both my husband and I wanted the baby very much, and neither one of us was willing to terminate the pregnancy on a "maybe." ...
>
> I had the amnio on 12/26/05, and the results came in on Jan. 13, 2006. It confirmed without doubt – she had Cat Eye Syndrome tetrasomy in every cell of her body. The last 3 sonograms showed ... our baby's kidneys were beginning to malfunction....
>
> We made this decision because we loved our daughter so much. We didn't want her to suffer the definite and the untold problems she was sure to endure, if she even made it. We made the best decision we could with the information we had. We fought for her. We wanted her. But we didn't want to condem[n] her to [a] life of agony.

Carrie, submitted by e-mail, May 30, 2006, at 111-13.

Beyond the time it takes to obtain a diagnosis, there is the time it takes to decide what to do when the diagnosis is devastating. Heather, a 33-year-old woman from the Midwest, explained:

> It took me an agonizing week to make this heartbreaking choice, but in the end I know it was the best decision for me, my family and most importantly, our child. We lost our oldest son at 6 years and 10 months old, to complications from having a rare type of dwarfism. That dwarfism was exactly the reason why we had the CVS test

> done. We knew without a doubt that we could never in good conscience bring another child into this world with that disease. . . . Most genetic defects come with their own list of extra problems, which I didn't take into account, and put that child at risk for painful procedures and even death. No child deserves to come into a world of pain. That is what made my decision for me. . . .

Heather, submitted by e-mail, May 17, 2006, at 65-66.

Women repeatedly state that one of the main reasons they choose to terminate wanted pregnancies is that the information they learn in the second-trimester confirms, if the fetus were to survive, its life would be short and fraught with pain. One 37-year-old married woman and mother of a three-year-old daughter, explained:

> So all the fluid was shown on the brain [and] stomach and [the physician] believed the baby had a very severe case of heart defect. And most likely – 90% chance that he was going to die in utero. . . . And even the 10% that he was going to be born he wasn't going to live very far without, I mean, even with major interventions it was very unlikely that he was going to survive. . . . [S]o at the time, we made a decision to terminate because I couldn't – knowing the outcome of what was going to happen I just couldn't carry on. I mean why put the baby through suffering if I can end his life and set him free of his suffering that he had to endure. That was our thinking.

Jane Doe, telephone interview, May 10, 2006, at 123.

Another woman and her husband learned at 18-20 weeks ("depending on which sonogram was right") that their pregnancy had Turner Syndrome. They too decided to abort to spare their child's suffering:

> Apparently, the lymph nodes didn't seal off, and the body was filled with fluid. This fluid was pushing on all the organs, and restricting the growth of the heart and lungs. . . . She was drowning from the inside, and I was able to save her from that immeasurable pain.

Jane Doe, submitted by e-mail, May 9, 2006, at 78-79.

Kara, a married woman with a three-year-old daughter from the Mid-Atlantic, learned at 25 weeks that her fetus was "missing a chamber of her heart which was causing a back flow of blood into another chamber and good and toxic blood were mixing":

> The physician . . . said if everything goes perfectly, [the child] will have to undergo 3 open heart surgeries and still will not have a long life expectancy. She couldn't tell us how long she would survive. She said "it could be a year, maybe three, maybe ten. That is, if she survives the pregnancy to term, the C-section, and all the surgeries." After the surgeries, she would be plagued with heart infections and would be constantly monitored at the hospital. If we were lucky and she did survive long enough to walk, she would never be able to run and play with her sister. . . .
>
> This is not the life we wanted for our precious little girl. Not only would she suffer her entire existence but it would have emotionally destroyed our other little girl as well.

Kara, submitted by e-mail, May 17, 2006, at 115-16.

Jane Doe, a 21-year-old woman from the Northeast, decided to end her pregnancy after her fetus was diagnosed with Turner Syndrome:

> [I]t was my first pregnancy so I went to the doctor and they found out [it] had Turner Syndrome and they told me my options and . . . they were

> surprised that she lived as long as she – her legs – she was swollen, one side of her body was swollen and she had a tumor around her neck and there wasn't enough fluid. . . . I made up my mind to have the procedure done 'cause I didn't know if she was suffering, 'cause she didn't have enough fluid, so I didn't know if she was ill. Nobody knew. They couldn't tell me so I feel like I had to do . . . what was best for her and that's what I thought was best for her. . . . I know like I did it for a good reason but it's like I don't regret it, but it's still hard. Because I really wanted my child. . . . Me personally I would [have] never thought I would have to get an abortion because no matter how young, if I was 15 and I got pregnant I would you know and everything was okay. Even if my child had Down Syndrome I would've had my child. But knowing that my child is swollen and there's not enough fluid and they don't know . . . if there's something wrong with her like if she suffers. . . .

Jane Doe, telephone interview, May 5, 2006, at 134-35.

B. Pregnancy Imperils Women's Health in the Second Trimester.

Another reason women decide to have a second-trimester abortion is because their pregnancies imperil their own health. Again, because these pregnancies are wanted, these women will often wait until the last possible moment to have an abortion, hoping to carry the fetus to term. Melissa, a 33-year-old nurse, described her situation:

> I have Lupus. The first 12 weeks or so were pretty normal. Then I was put on bed rest. . . . I had discharge, cramping. . . .

> I was real sick – with the disease and complications. Practically every complication that I could have – pre-term labor, starting first trimester, cramping, shortening of the cervix all the way through. . . .
>
> I was put on bed rest for another week and told to drink fluids constantly but then I started hemorrhaging. . . . They put me on bed rest in the hospital, upside down, with daily ultrasound and IV calming medicine but my fluid kept getting lower. About 5 days later, the doctor said I had to make a decision. . . . The baby was not viable. The doctor said the baby could not survive without fluid. I begged for another day. This was a Catholic medical center. . . . The doctor said I'd have to go elsewhere to terminate. I was in a slight Lupus flare-up. . . .
>
> They wouldn't transfer me to another hospital. They wouldn't make any arrangements. . . .
>
> I made the arrangements myself. I called [the local clinic] and was blessed to speak [to the counselor there].

Melissa, telephone interview, May 26, 2006, at 162-64.

Sara learned during her wanted pregnancy that it was, in fact, a molar pregnancy.[18] Notwithstanding this tragic diagnosis, she tried to continue with the pregnancy:

> I had early onset preeclampsia.[19] . . . My blood pressure which is usually around 110 over 70

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[18] Molar pregnancies are non-viable 100% of the time whether "complete," in which case no fetus is formed (although the placenta may develop), or "partial," in which case the fetus has serious abnormalities. Treatment for molar pregnancy is the removal of the pregnancy. *See* WILLIAMS, *supra* n.11, at 274-78.

[19] Preeclampsia is a rapidly progressive condition where a woman's blood pressure becomes seriously elevated and she develops large

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> was floating around 220 over 135. And all the attendant problems – the kidneys, the water retention were a nightmare. . . . And there was great risk of stroke or seizure associated with the blood pressure. . . . And I also had the placenta previa – the placenta blocking the birth canal – and the placenta was also abnormally massive so even if my body had tried to spontaneously end the pregnancy it would have created a different set of problems with me. If that placenta was ruptured there was a great chance that I would have massive hemorrhaging or – so we didn't have many options. And the preeclampsia was just gonna get worse. . . . My child was dying and I was really sick. . . . Eventually they . . . gave me the option to do D and E, dilation and extraction. . . . [W]e did the D&E later that afternoon.

Sara, telephone interview, June 16, 2006, at 150, 152-53.

Jane Doe, a 19-year-old from the Midwest, has PKU disorder[20] and describes:

> My PHE levels are too high to bring a child in this world [a]nd not expect to have some medical problems. My child is almost guaranteed to be

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amounts of protein in her urine. It typically occurs after 20 weeks' gestation. Treatment is the removal of the fetus. *See id.* at 763, 787-88, 797; *see also* Nat'l Inst. of Health, Nat'l Library of Med., *avail. at* www.nlm.nih.gov/medlineplus/ency/article/000898.htm (visited Aug. 9, 2006).

[20] Phenylketonuria (PKU) results from an enzyme deficiency that, untreated, leads to elevated levels of the amino acid phenylalanine (Phe) in the bloodstream. Fetuses exposed to high levels of Phe are vulnerable to mental retardation, congenital heart disease, and other disorders. *See* WILLIAMS, *supra* n.11, at 192, 296-97; *see also* Nat'l Inst. of Health, Press Release, NIH Consensus Panel Recommends Comprehensive Approach to Life Long Care for PKU (Oct. 18. 2000), *avail. at* www.nih.gov/news/pr/oct2000/omar-18.htm (visited Aug. 9, 2006).

> born and live only 2 or 3 years or be born and have mental retardation, [h]eart defects, and a very small head. I can't be selfish like that and have this child under the circumstances.

Jane Doe, submitted by abortion fund, Feb. 1, 2006, at 350.

Women also have second-trimester abortions to preserve their ability to have healthy children in the future. Amanda is a 27-year-old woman from the Northeast who lives with her boyfriend and their four-year-old son. She decided to have an abortion after learning that her pregnancy had a cystic hygroma caused by Turner Syndrome:

> Unfortunately it was quickly made clear that it was too dangerous to continue my pregnancy. The hygroma was too large on the baby's head. It was a guarantee that she was going to die. The only question was when. I tried to fight it. . . . If I waited and let her die naturally I would have risked my own health and possibly my ability to have any future children. . . . All possibilities ended with the same eventual outcome. My decision ended her suffering and kept us from prolonging the loss that was inevitable.

Amanda, submitted by letter, July 7, 2006, at 386-87.

Catherine and her husband of eight years live in the Midwest, and learned during the 14th week of pregnancy that their child had Trisomy 13 and that the pregnancy was threatening her health:

> [I]f I tried to carry to term and suffered a late-term fetal death or miscarriage, there was a serious chance of complications for me. I might hemmorrage [sic], I might get an infection, the trisomy might interfere with the development of the placenta and leave me deathly ill. My OB told me, in very plain language, that if I carried

> this pregnancy to term, there was a very high chance that I would never bear another child.
>
> There was no good choice. There was no hope of a healthy child. There was no hope of a living child. I could have an abortion, or I could see how my luck went with carrying this doomed pregnancy to term and risk my life and future fertility, and I elected to have an abortion.

Catherine, submitted by e-mail, May 26, 2006, at 50-51.

C. Obstacles Delay Access to Abortion.

Finally, some women find themselves in the second trimester of their pregnancies because they had problems accessing abortion services at an earlier time or because they only first became aware they were pregnant during their second trimester. Often, these women would have preferred to have abortions in the first trimester, but due to financial[21] or geographical[22] factors they were unable to do so.

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[21] The Federal Government and 33 states refuse to provide public funding for medically necessary abortions. As a result, low-income women on average delay accessing abortion an additional two to three weeks because of difficulties in obtaining funds. *See, e.g.*, Stanley K. Henshaw & Lynn S. Wallisch, *Medicaid Cutoff and Abortion Servs. for the Poor*, 16 FAM. PLAN. PERSP., July-Aug. 1984, at 170. This delay itself costs women money, as the average cost of an abortion increases as the gestational age of the fetus increases (along with the relative complexity of the procedure). *See also* Jane Doe, on-site clinic interview, June 23, 2006, at 299 ("today would've been 16 weeks. Which would've made it 200 more dollars. Then I would've been stuck trying to get 200 more dollars by Friday and then if I didn't get it next Friday it would've jumped up another 200 dollars so that's 400 I didn't get in 2 weeks and I can't pay my electric bill. . . . Money is a major issue.").

[22] As of 2000, abortion providers operated in only three nonmetropolitan counties in the United States and 87% of counties overall had no abortion provider. *See* Lawrence B. Finer & Stanley K. Henshaw, *Abortion Incidence and Servs. in the U.S. in 2000*, PERSP. ON

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For instance, Deria, a mother of three, noted that she delayed until the second trimester because: "I was just waiting for my insurance. That was the only reason. Because I got the new job and I had to wait for my insurance to kick in." Deria, on-site clinic interview, June 3, 2006, at 207.[23]

Tamera, a single mother of two, explained: "I was trying to get the money up but the longer you wait the more it is. Then I'm Rh negative so you have to pay for the shot. And it's just more and more. It builds up to the point where – what if I didn't have it today and it was $1500 in a week? And then it was almost $2000. . . . " Tamera, on-site clinic interview, June 3, 2006, at 232.

For women who do not live close to a clinic, there are often delays as they try to arrange transportation and the necessary funds. Liz, a 20-year-old woman from the Northwest, described her efforts to find a clinic where she could access an abortion:

> Once I realized and accepted I was pregnant, I made my appointment at Planned Parenthood of Idaho and was 5 days past the deadline. I was 14 weeks. Scared but being responsible I took a seven hour bus drive to Salt Lake City and was turned away again because I was 7 days past 18 weeks (which increases by $500). I therefore had to

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SEX'L AND REPROD. HEALTH, Jan.-Feb. 2003, at 6-15. Thirty-three percent of providers offer abortion services at 20 weeks gestation and 24% provide services at 21 weeks. Stanley K. Henshaw & Lawrence B. Finer, *Accessibility of Abortion Servs. in the U.S. 2001*, PERSP. ON SEX'L AND REPROD. HEALTH, Jan.-Feb. 2003, at 18.

[23] Seventy-four percent of women pay "out-of-pocket" for abortion procedures, and four states restrict private insurers from providing coverage except in cases that would endanger a woman's life if carried to term. *See* Guttmacher Inst., *State Policies in Brief, Restricting Ins. Coverage of Abortion*, Sept. 1, 2006, at 1.

> leave. . . . I am currently at [a clinic in Oregon]. . . . I am 21 weeks and am sure of my decision.

Liz, submitted by letter, May 11, 2006, at 25.

Some women do not realize for several months that they are pregnant. Many of the women interviewed were on birth control and thus were not anticipating the possibility of pregnancy. Crystal, a 20-year-old married woman, explained:

> I had an IUD inserted in early November, and I was told that it was common for women to stop menstruating. I conceived a week after my IUD was inserted, despite using condoms as a back-up method. I wasn't even aware I was pregnant until the end of January, and even then, I only took a test out of paranoia. . . . The risks from an IUD pregnancy, coupled with our financial situation led us to make the decision for abortion. It was too soon for us to have another child. My daughter is still just an infant, and deserves all our love and attention.

Crystal, submitted by e-mail, May 15, 2006, at 59.[24]

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[24] The rights to privacy and personal liberty have long been recognized to include the right to use contraceptives. *See, e.g., Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972); *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965). No contraceptive is 100% safe and effective, however, and as demonstrated in the women's stories, contraception often fails despite conscientious use. *See* AMERICAN ACAD. OF FAMILY PHYSICIANS, CHOOSING A BIRTH CONTROL METHOD THAT'S RIGHT FOR YOU 2 (2005), *avail. at* http://familydoctor.org/016.xml; *see also* Krystal, submitted by e-mail, May 5, 2006, at 76 ("I thought in my head 'I know I'm not pregnant I'm on birth control' "); Jane Doe, on-site clinic interview, June 2, 2006, at 189 ("I was on birth control. I had gotten sick and was on medication, which I found out afterwards had made my birth control less effective.").

Others were young and unfamiliar with their bodies and did not recognize the signs of pregnancy.[25] For example, one 16-year-old explained she did not realize she was pregnant:

> I just felt tired all the time. I just thought it was stress because I was like studying for my finals and everything. I guess I was like I don't feel good. Always had these headaches or something. So, I was like it's just stress, it's just stress. So I would just like run. The first time I went to the doctors and I found out . . . it was just a big shock.

Jane Doe, on-site clinic interview, June 23, 2006, at 302.[26]

Still other women experienced stressful life events that masked the source of their missed menstrual cycles. Rahel explained:

> I was unemployed and had no health insurance . . . I had no doctor, I had no gynecologist and was just trying to get a job so that I could support myself and take care of my immediate needs. So my health was very secondary. Also, because of my personal health history it was normal for me to not menstruate for extended periods of time . . . especially when . . . I'm feeling

[25] Teenagers face an additional "serious, and in some cases insurmountable barrier" to abortions in states with parental involvement laws, especially teens in rural areas. *See* Patricia Donovan, *Judging Teenagers: How Minors Fare When They Seek Court-Authorized Abortions*, FAM. PLAN. PERSP., Nov.-Dec. 1983, at 259. One young woman, for example, delayed until she turned eighteen years old in order to have the abortion without her parents awareness. *See* Jenna, submitted by letter, June 12, 2006, at 24.

[26] Some young women delay in response to the stress of being pregnant. *See, e.g.*, Alyssa, submitted by letter, July 28, 2006, at 370-71 ("I am 15 years old and almost 18 weeks pregnant. When I found out I was pregnant I was very confused. I found out when I was about 6 weeks pregnant. I didn't go to the doctors until I was almost 13 weeks pregnant.").

> stressed. . . . So because of those factors I just wasn't aware of what had happened.

See Rahel, telephone interview, May 24, 2006, at 145.[27]

Finally, some women recounted being victims of sexual assault and either wanted to avoid the possibility or were embarrassed to tell others why they were pregnant. For example, Tina described being the victim of a rape witnessed by her seven-year-old daughter. Tina did not initially know she was pregnant, explaining, "[I don't] want to have the baby given the way it happened." *See* Tina, on-site clinic interview, May 24, 2006, at 235.[28]

III. Women Choose Second-Trimester Abortions for Moral and Intimately Personal Reasons.

Regardless of the circumstances that lead them to consider a second-trimester procedure, individual women do not choose abortion lightly.[29] For some, God and faith

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[27] Rahel's story indicates that she obtained an abortion by the D&X procedure targeted by the Ban and for which there is no health exception.

[28] *See also* Jane Doe, on-site clinic interview, June 2, 2006, at 180-81 ("He forced his way into my door into my living room and raped me on my living room floor . . . . I . . . got the pregnancy test. And it was so positive. . . . And I cried for days."); *see also* Jane Doe, submitted by letter, July 28, 2006, at 367 (explaining that her 19-year-old daughter was having an abortion after being raped in her dorm room in January 2006). The Federal Abortion Ban contains no exception for women who have been raped.

[29] The women's stories consistently reveal that they weigh the decision to terminate seriously. *See also* Jenny, submitted by letter, June 28, 2006, at 317 ("It is a big decision and you need to weigh out our [sic] pros & cons and sometimes it takes a while.").

figure prominently into their decision-making process.[30] For others, the choice to have a second-trimester abortion reflects their desire to pursue an education to improve their futures and to have children if and when the time is right. The decisions of others are informed by strong considerations of family, including what the impact of another child will have on their already-existing children or on their ability to have children in the future.[31]

A. Women Consider Religious Values.

Many women appeal to their religious beliefs to help them decide what to do when considering a second-trimester abortion. Catherine, a 38-year-old woman, described her decision to terminate her pregnancy at "two days shy of 20 weeks gestation":

> This was not an easy decision for me or my husband, as to what to do next. . . . My husband is Catholic, albeit non-practicing, and really struggled with what to do. I have considered myself to be Pro Choice my entire life, but always felt like I would never be able to have an abortion myself. (Besides, I didn't think I'd ever even NEED to consider it.) . . .
>
> When I called to make the appointment I was told I could not get in for another week. Having

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[30] According to one study, in the general population, 43% of women who had abortions identified as Protestant, 27% identified as Catholic, and 8% as a member of another religion; 22% report no religious affiliation. Thirteen percent identify as "born-again" or evangelical. Rachel K. Jones, *et al.*, *Patterns in the Socioeconomic Characteristics of Women Obtaining Abortions in 2000-2001*, PERSP. ON SEX'L AND REPROD. HEALTH, Sept.-Oct. 2002, at 228.

[31] In the general population, 52% of women having an abortion intend to have children or more children in the future. *Id.* at 230. Six in ten women who have an abortion are already a parent. *See* Strauss, *supra* n.8, Table 12.

> to wait another week, knowing that the life I could feel moving inside of me – the baby that we conceived purposely and in love – was not going to be there much longer was agonizing to a degree I cannot describe. I prayed every night to God to please take my baby boy peacefully. When he wouldn't move for a few hours I hoped God had answered my prayers . . .

Catherine, submitted by e-mail, May 16, 2006, at 45-47 (emphasis in original).

Tina, a 32-year-old married woman with a healthy two-year-old son, learned at 23 weeks that her fetus was afflicted with Trisomy 18. She explained:

> God determined his fate not my husband and I. He was going to die no matter what. We may have ended his life sooner but it was to not see him suffer. We did extensive research on this condition and knew the odds were not in his favor. We also asked many questions before making the decision to abort. . . . Put yourself in my shoes and try to understand how it would feel to carry a baby full term with the knowledge that it may or may not be born alive and if it is born alive may live a few hours.

Tina, submitted by e-mail, June 7, 2006, at 89.

For Gina, religious beliefs influenced her decision to terminate her pregnancy and to request an intact procedure after a diagnosis of several fetal anomalies:

> As a Christian and a married woman who desperately wanted a child, I'd never given much though[t] to abortion. . . . We called our pastor, who told us there was no cut-and-dried answer and urged us to make whichever decision would bring our [in utero twin] daughters the most life. "Whatever you do," he said, "we'll support you." In fact, everyone – relatives, church members, colleagues – offered us their unconditional support

> throughout the entire process. "Nobody here has walked in your shoes," our pastor's wife told us, "and nobody here can judge you. . . . "
>
> Even as I [made] the appointment, I was still hoping God could save [the in utero twins]. But if he couldn't, I wanted to be able to hold them and say goodbye before I lost them forever.

Gina, submitted by e-mail, May 3, 2006, at 107-08.[32]

Jane Doe is from the Midwest and became pregnant after she was displaced from her home. She explained:

> The lord forgives us all + I pray to him daily. . . . I know God puts us through things for a reason + don't give us nothing he don't think we can handle but I can't do this one . . . We as women + parents do things for different reasons, I have a son that I been taking care of on my own + I can't afford another one right now. . . . The lord knows our decision + what we will do before we do it so I already feel like he forgave me because that's what he does, he's a forgiver – a healer, I call on him to help me get through this because I know he always listen. I rather have my kid in heaven than hell on earth because that [sic] what he/she will get if I was to have it.

Jane Doe, submitted by letter, July 7, 2006, at 314-15.

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[32] Gina recounts that she requested a D&X abortion so that she could hold her daughters intact after the procedure. *See* Gina, *supra*, at 108. Prior to the availability of D&X, women who wanted to obtain an intact fetus to hold or for genetic testing purposes would terminate by induction. Induction abortion simulates a labor delivery. It can take hours and, prior to 20 weeks gestation, presents comparatively greater risks to a woman's health than D&X. *See, e.g.*, *Stenberg*, 530 U.S. at 926.

B. Women Consider Self-Determination Values.

Many women who have second-trimester abortions value their ability to control when and if they will have children, even while most women do eventually become mothers. Angela submitted her account of obtaining an abortion when she was 19 years old:

> At the time of my abortion I did not have any children, and I was obviously not married. I am now married and have a daughter who will turn four in June. She is a joy and the feelings I had when I was pregnant with her were completely different considering my life circumstances and the fact I was having a baby that we both wanted. I can't say I was ready, or ever would have been, but I was comfortable and knew we would be ok. I was 23 when she was born, and am still married to her father. . . .
>
> I don't really think about "what if I had the baby?" And if the thought ever does cross my mind, it is full of gratitude for the doctor that provided the service to me.

Angela, submitted by e-mail, May 24, 2006, at 40.[33]

In particular, many women choose to terminate their pregnancies so that they may have children when they are financially and emotionally able to provide for them. One 17 year old reflected:

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[33] Many women expressed gratitude not only to their physicians, but also for their ability to obtain a safe abortion. *See, e.g.*, Jessica, submitted by e-mail, May 12, 2006, at 69-70 ("I can also tell you that I'm so very grateful that I had the choice to make when nature didn't do her job."); Plata, submitted by e-mail, May 25, 2006, at 82 ("I went to [another state] for termination and was glad to know that the procedure was safe, legal and done with the utmost professionalism."); Kim, telephone interview, June 17, 2006, at 143 ("I thank God that I have that freedom and that right to make the decision and for that to happen").

> I was approximately 22 weeks when I received the abortion procedure. At the age of 17 years old there was a small possibility that I would be able to support myself let alone the life of a needy child. Considering that I have very little experience with taking care of children, was also a reason for me getting the procedure. I would be a single parent so therefore I was not ready to take on that responsibility alone. The procedure didn't [a]ffect me in a harmful way, but it helped me maintain my life and be able to become someone. My decision was a huge help for my goals in life. I am now able to achieve my goals and look forward to a beautiful future. Maybe one day I will be able to have a child and have no doubts about being able to support it.

Jane Doe, submitted by letter, June 12, 2006, at 14.

For many of the younger women who shared their stories, the ability to pursue an education and shape their future figured largely into their decisions. Laura was a 19-year-old honors student on the West Coast when she had a second-trimester abortion:

> I knew in my heart that abortion was my only realistic choice. . . . [A]fter working so hard to get into [college] and setting myself for what I hoped would be a long, fulfilling, successful career, I could not accept the idea of putting it all on hold to have a child, most likely alone, and possibly without parental support. . . .
>
> I also wonder, at times, what my parents would have thought. I got my answer years after my abortion, when my best friend became pregnant and decided to forgo medical school in order to have a baby. My mother – a devout, conservative Christian – told me, in hushed tones, should I ever find myself pregnant she would personally take me to get an abortion. She said my future was too important. I was shocked to hear it – given her beliefs

> and politics – but also somewhat relieved and reassured. In her own way, she understood that the right to choose abortion was central to any woman's ability to live a full life.

Laura, submitted by e-mail, May 8, 2006, at 119-20.[34]

Another young woman explained "I'm leaving for the Army in August. I'm already signed up, I'm ready to [g]o and I want to go and it's like that [the pregnancy] is going to prevent me from going." Jamie, on-site clinic interview, June 1, 2006, at 210.

C. Women Consider Family Values.

Many of the women choose to terminate their pregnancies because of their strong commitment to their families. For example, many women consider the financial and emotional toll another child would have on their ability to provide for themselves and their children. Kourtney, a 35-year-old woman and single mother who lives in the Northeast, described:

> I was raised in a very conservative [C]hristian home in which I was taught at age five that abortion was murder. I was taken to protests and rallies throughout my entire childhood. . . .
>
> I never thought I would be a single mom but here I was alone, thousands of miles away from my family. . . . I have a masters level education and a professional job. Even with a good job and an education, after paying for child care ($17,000 per year), health insurance ($5,200 per year) I have only $400 per week on which to support my three children and myself. . . .

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[34] In her e-mail, Laura indicates that she had an abortion in October 1994.

> I was lucky to get the children in bed every night by 9 so that I could do the dishes, laundry, vaccuum [sic], pay the bills, etc. Physically and emotionally I had nothing to give to myself and I knew what I had for my children was not enough. How could I possibly manage another child? . . . I prayed, I cried, I begged, and I screamed every night. . . .
>
> I decided to take the chance that I would survive and that my three children would have their mother to raise them, rather than having four children with a mother who was destined to be in a mental hospital.

Kourtney, submitted by e-mail, May 17, 2006, at 73-74.

Lucinda from the Midwest is a 29-year-old mother who explained her decision to have an abortion:

> Due to being in a relationship over the past 5 yrs. which has turned abusive the last year. And being hit in the stomach at 8 wks. pregnant. I made the choice that it [sic] best for the future of myself and my 10 yr. old and the mental and physical well being of my baby that I wait until a later date to bring another life into this already confusing world. . . . I prayed and felt that this was the best choice for everybody.

Lucinda, submitted by letter, June 16, 2006, at 320.

Christine, a 21-year-old woman from the Northwest, considered not only her two-year-old, but also her parents after her boyfriend abandoned her 14 weeks into her pregnancy:

> I knew that having this baby would take a lot of what i [sic] could give to my daughter away. I would not be able to get my own place in time to have this child and I knew that I would have to take care of him and my almost 2 year old in one bedroom. This is not something that I wanted for

> the daughter that I already had nor was it something that I wanted for a newborn baby. I knew that I would have to rely on my parents who are practically in their fifties, that still work their butt's [sic] off everyday to take financial responsibility for my children. This is not what I wanted for my parents either. . . . I want to be able to stand on my own two feet. . . . I didn't want to sole[l]y rely on the feet of others. I knew that having this baby would not enable me to do those things in time for this child to be born. I don't think it would be fair to either one of my children (born and unborn) to do that to them.

Christine, submitted by e-mail, May 25, 2006, at 56.

CONCLUSION

The stories of individual women provide the Court with a window into why women obtain second-trimester abortions. For individual women who face the decision regarding a second-trimester abortion, their ability to obtain safe abortions is fundamental to their lives. In making this decision, these women rely upon intimate moral, religious, and personal values to make the right decision for themselves and their families. This is the essence of a woman's right to privacy and liberty, and *Amici* ask this Court to hold the Federal Abortion Ban unconstitutional and affirm the decisions of the Eighth and Ninth Circuits.

Dated: September 20, 2006

Respectfully submitted,

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APPENDIX OF *AMICI CURIAE*

I. The Institute for Reproductive Health Access

The Institute for Reproductive Health Access works through research, education and advocacy to increase access to comprehensive reproductive health services, reduce unintended pregnancy, and protect the constitutional right of women to make private health decisions that affect them and their families. The Institute partners with state-based organizations throughout the United States to remove the obstacles women face when seeking to obtain family planning and abortion care, as well as other reproductive health services.

II. ABORTION CLINICS

Allegheny Reproductive Health Center (PA)

Allegheny Reproductive Health Center, located in Pittsburgh, PA, provides reproductive health care to women and men from Pennsylvania, Ohio, West Virginia, and Maryland. Founded in 1975, Allegheny Reproductive provides contraception, abortion services, gynecological care, patient education and related counseling. For more than thirty years, we have heard the stories from the hearts of the patients we serve who are making moral choices for their families' well-being.

Allentown Women's Center (PA)

The Allentown Women's Center (AWC) is an independent provider of abortion and reproductive health care services in Northeast Pennsylvania. Founded in 1978, AWC has provided vital health care services to over a hundred thousand women between the ages of eleven and

sixty. AWC serves numerous counties within a 50-100 mile radius of Allentown, in both Pennsylvania and New Jersey. AWC supports and respects the right of every woman to make her own decisions regarding her reproductive health care and sexuality. Through education, outreach, and counseling support, AWC aspires to help create an environment where women will not be judged and harassed for their choices, but praised for their strength and courage.

Atlanta Women's Medical Center (GA)

For over thirty years, the Atlanta Women's Medical Center has set a standard for excellence in first and second trimester abortion care for the women of Georgia and beyond. We are an accredited member of the National Abortion Federation and the National Coalition of Abortion Providers. Our community depends on us to provide them with the safest care available, and that we will serve them to the best of our ability. A woman's ability to determine the best course of action is essential to providing safe and excellent care, and this ability must be preserved.

Aurora Medical Services (WA)

Aurora Medical Services is a private women's reproductive health clinic, providing medical and surgical first trimester abortions, surgical second trimester abortions, donor insemination, birth control methods, STD testing and treatment, and well-woman care. We believe that each individual woman is the person best qualified to decide when, where, how, and whether or not she should bear children.

Buffalo Women's Services, LLC (NY)

Buffalo Women's Services, LLC has been providing quality abortion care to thousands of women since 1983. We provide abortion services from four weeks to twenty weeks, and see women from Western New York, Ohio, and Pennsylvania. We also do termination for fetal indications up to twenty-two weeks. We also provide routine gynecology and birth control. We are a member of the National Abortion Federation and are active in the political arena, fighting for reproductive rights for all women.

Camelback Family Planning (AZ)

Camelback Family Planning, located in Phoenix, Arizona, provides reproductive health services to women and men throughout the Southwest. Since opening in 1999, CFP has provided contraception, abortion care, and general gynecological care, and every day we hear our patients' stories about their families. The outcome of these cases will impact our services.

Cedar River Clinics –
Feminist Women's Health Center (WA)

To achieve reproductive freedom and justice for women, Feminist Women's Health Center operates Cedar River Clinics which provides first and second trimester abortion in Renton, Tacoma, and Yakima in Washington State. We are one of the few clinics providing out-patient terminations for women with severe fetal anomalies or risks to the women's health. Annually we serve over 7,000 women for a range of gynecological services. We are a social justice organization that combines direct health care with community education and activism to assure all

women have the right to determine their reproductive destinies. We have a vision of a world where all women freely make their own decisions regarding their bodies, reproduction, and sexuality – a world where women can fulfill their own unique potential and live healthy, whole lives.

Cherry Hill Women's Center (NJ)

The Cherry Hill Women's Center is a state-licensed Ambulatory Surgery Center specializing in first and second trimester abortion care. We are an accredited member of the National Abortion Federation and the National Coalition of Abortion Providers. Since 1978, our mission has been to exceed expectations in women's health care and set the standard for dignified, confidential reproductive health services. We strive to treat each woman as a whole person, addressing her physical and emotional needs so that she can make informed health care decisions, and we work to educate our community about the importance of comprehensive reproductive health care in order to increase understanding of the complexity of reproductive health care decisions. We feel it is essential for the voices of women who seek and desperately need our services to be heard.

Concord Feminist Health Center (NH)

Concord Feminist Health Center (CFHC), a nonprofit women's health clinic located in Concord, New Hampshire, provides comprehensive gynecological care and abortion services to women in New Hampshire and the New England region. CFHC was founded in 1974 on the belief that women understand their bodies and make intelligent

health choices when they are provided with accurate information, understanding, and support. Additionally, CFHC takes an active role in community and national politics; we are continually involved in the ongoing struggle to preserve and expand women's rights.

Crist Clinic for Women (NC)

Founded in 1973, the Crist Clinic for Women is an OB/GYN clinic with eighteen professionals that provide full women's services and support women's rights and reproductive freedom – "All women have a RIGHT to determine their own destiny." The clinic has five OB/GYNs, a Nurse Practitioner, a Midwife, and several ancillary staff support – all proud to be included as amicus.

Curtis Boyd, M.D., P.C. (NM)

Curtis Boyd, M.D., PC has been providing abortion services in New Mexico since 1972. The clinic specializes in pain management, offering individual counseling to each patient. The clinic is a member of the National Abortion Federation and provides high quality, low cost services through the second trimester for women throughout the Southwest.

Family Planning Associates (IL)

Family Planning Associates Medical Group is a women's healthcare provider with three locations in the greater Chicago area. We have been a member of the community for over eighteen years, and we're the largest provider of second trimester abortions in the Midwest. We

are also a member, in good standing, of the National Abortion Federation. We are committed to a wide range of women's issues, primarily focusing on women's reproductive rights. Women of all ages, races, and circumstances seek our services.

Family Planning Association of Maine (ME)

The Family Planning Association of Maine is a statewide nonprofit organization whose mission is to meet the full-range of clinical and educational reproductive health needs of low-income women and teens living in Maine. Founded in 1974, the Association has been the state's Title X/National Family Planning grantee for the last thirty-two years, and for the last fifteen years has successfully competed for all state funds dedicated to serving the reproductive health needs of Maine women and teens. Additionally, the Association offers abortion services in two health sites and is home to a training facility in northern New England for physicians and family practice and OB residents interested in learning how to provide abortion services.

Fayetteville Women's Clinic (AR)

Located in Fayetteville, Arkansas, the Fayetteville Women's Clinic has been providing reproductive health care since 1979. The Fayetteville Women's Clinic has provided most of the elective abortion care in northwest Arkansas since 1984 when it became the sole clinic outside of Little Rock openly willing to provide this vitally important service. The Fayetteville Women's Clinic provides surgical abortions from the time pregnancy has been diagnosed and the abortion decision made to 18 weeks,

and medical abortions to 9 weeks after the last menstrual period with certain restrictions.

Hartford Gyn Center (CT)

Hartford Gyn Center is a member of the National Coalition of Abortion Providers and the National Abortion Federation. We have been providing abortion services to the women of New England since 1981, and have great interest in these cases, as the decisions will either uphold or erode women's access to reproductive freedom. It is our opinion that the decision to terminate a pregnancy should only be made by the woman and anyone she may choose to include in her decision, such as a parent, a partner, or a member of the clergy.

Hillcrest Clinic – Baltimore (MD)

The Hillcrest Clinic was established in 1973, and every day in our thirty-three years of existence we have seen the need for safe, legal abortion services. Our doctors, nurses, counselors, and support staff provide an atmosphere of understanding and respect to women who are dealing with unwanted pregnancies as well as many other problems. Our main objective is to provide women with quality medical care and professional counseling in an atmosphere of confidentiality and respect, at an affordable cost.

Hope Clinic for Women, LTD (IL)

The Hope Clinic for Women, LTD opened its doors in 1974 and is a state licensed Ambulatory Surgical Treatment Center (ASTC) that specializes in abortion care. We

were one of the first clinics in Illinois to offer procedures past the first trimester because the owner and then medical director of the clinic recognized the need. Our services include a full range of abortion care as well as birth control education, counseling, a speaker's bureau, and written educational materials. Though our tax status is for-profit, our goal is to never deny a woman the services she needs due to lack of financial resources.

Memphis Center for Reproductive Health (TN)

The Memphis Center for Reproductive Health (MCRH) is a 501c3 nonprofit women's reproductive health center licensed as an ambulatory surgical treatment center through the state of Tennessee, with a clinic located in Memphis, Tennessee. Founded in 1974, MCRH provides gynecological exams, testing for sexually transmitted infections, and abortion care services for women from more than five states including Tennessee, Missouri, Mississippi, Arkansas, Alabama, and Kentucky. MCRH also provides ongoing education through community outreach in west Tennessee, east Arkansas, and north Mississippi.

Mildred S. Hanson, M.D. (MN)

Mildred S. Hanson, M.D., is a gynecologist practicing in south Minneapolis. She was the first physician in Minnesota to offer second-trimester D&E procedures. She also provides medical abortions using Methotrexate and oral prostaglandin for very early terminations on request.

Mile High OB/GYN Associates, P.C. (CO)

Mile High OB/GYN is a five-physician OB/GYN practice established more than fifty years ago in Denver, Colorado. We support the reproductive rights of all women, and we provide the totality of OB/GYN services, including second trimester termination. We are associated with a genetics clinic and have helped many women with fetal anomalies, lethal anomalies, and chromosomal abnormalities.

Northeast Women's Center (PA)

Founded in 1973, the Northeast Women's Center was the first free-standing abortion provider in Pennsylvania, and has been an integral part of the community since that time. We are an accredited member of the National Abortion Federation and the National Coalition of Abortion Providers, and provide first and second trimester abortion care in a safe and dignified manner.

Northland Family Planning (MI)

Northland Family Planning Centers are three centers founded in 1976 that provide reproductive health care services including abortion care up to twenty-four weeks. We serve women who need abortion care in the city of Detroit, Michigan, as well as a three-county area surrounding Detroit.

Philadelphia Women's Center (PA)

Philadelphia Women's Center has been specializing in first and second trimester abortion care and women's health care services since 1972. As a progressive leader in

the community, we strive to meet and exceed the changing needs of our patients. As members of the National Abortion Federation and the National Coalition of Abortion Providers, we understand the issue of reproductive rights as it plays out on both a national and local level. At Philadelphia Women's Center, we strive to treat each woman as a whole person, addressing the physical and emotional needs so that she can make meaningful, informed healthcare decisions. Reproductive healthcare decisions are exceedingly complex, and talking with our patients each day teaches us that no two women come to a decision about abortion in the same way. As abortion providers, we are concerned about not only the quality of care women in our community receive, but access to this care as well.

Preterm (OH)

With more than 30 years experience, Preterm of Cleveland, Ohio, offers both surgical and medication abortion services as well as free pregnancy testing and emergency contraception. Preterm provides surgical abortion care from 4 through 20 weeks of pregnancy, and medication abortion from 4 through 8 weeks. Preterm's Fetal Anomaly Program offers specialized services for families experiencing the profound grief of having to undergo a pregnancy termination due to a fetal abnormality.

Reproductive Health and Counseling Center (PA)

The Reproductive Health and Counseling Center (RHCC), located in Chester, Pennsylvania, exists to provide high quality, comprehensive reproductive health care for well women and men. When the Supreme Court

decided in 1973 that the choice of terminating a pregnancy was between a woman and her doctor, RHCC began providing pregnancy testing, first and mid-trimester abortion services, counseling services, contraceptive care, and routine gynecological care. An important part of our service to women from our area is second-trimester abortion services, which leads us to support this brief as amicus.

Scotsdale Women's Center (MI)

Scotsdale Women's Center (SWC) was founded in 1973 in Detroit, Michigan. For thirty-three years we have offered pregnancy termination, ob/gyn care, family planning, and counseling for our mostly inner-city patients. SWC is run by women who are active in the pro-choice community, striving to protect reproductive rights and freedom. Our Director has been a member of MARAL (Michigan Abortion Rights Action League) since 1975. Since the founding of SWC, our counselors have discussed with our patients the difficult decisions they have chosen to make.

Seattle Medical & Wellness Clinic (WA)

The Seattle Medical & Wellness Clinic is a private physician-owned clinic established in 1985. The clinic provides a range of services including abortions up to nineteen weeks. We serve the military and student populations of Western Washington State, but we also have patients from as far away as Alaska, Saskatchewan, California, and Idaho. Our mission is to provide the most competent and supportive care for women who choose abortion.

Southern Tier Women's Services, Inc. (NY)

As a health care facility that provides first trimester abortions, we are interested in this case because we see first hand how much women need our services. Many women have a difficult time raising money, arranging time off from work, arranging childcare, transportation, etc., thus delaying them to a second trimester procedure. It is our experience that women take the responsibility of childbearing very seriously, and that this is the main issue for them – providing for a child.

West Alabama Women's Center (AL)

West Alabama Women's Center located in Tuscaloosa, Alabama, provides reproductive health care to women from Alabama, Florida, Mississippi, and Georgia. We consider the availability of abortion services an essential means of assuring that children will be planned, loved, and cared for. Therefore, one of our goals is to preserve and assure access to safe, legal abortion services for all women. Every woman's body is different and so is every woman's life.

Westside Women's Medical Pavilion (NY)

Westside Women's Medical Pavilion, founded in 1996, offers a wide range of health care for women, including reproductive health care. While we are located in the Northeast, patients are referred to us from a wider area. Additionally, through our affiliations with nearby hospitals, we participate in the education of young physicians in the area of female reproductive health care.

Whole Woman's Health (TX & MD)

- Austin
- Baltimore
- Beaumont
- McAllen
- San Marcos

Whole Woman's Health is a patient-centered women's healthcare practice, where the focus is on the whole woman – her head, her heart, and her body. We believe that all health care, especially women's health and abortion services, can better serve our community through a holistic approach. We explain medical procedures and share their results, and we also pay attention to how our patients feel, because we have all been patients before, and we understand the fear and anxiety often experienced in medical settings.

Women's Health Project, Inc., d/b/a Emma Goldman Clinic (IA)

The Women's Health Project, Inc. is a reproductive health care organization located in Iowa City, Iowa, serving clients from throughout the Midwest since 1973. The services provided include gynecology, abortion, walk-in, and massage, as well as health care education and political advocacy on issues related to our mission.

Women's Health Services (MA)

Women's Health Services provides second trimester procedures up to twenty-three weeks. Our population includes females between the ages of twelve and forty-seven, from every economic and ethnic group. Approximately forty percent of our patients are women who have

pregnancies with chromosomal abnormalities, congenital defects, or fetal demises that have not been diagnosed until after thirteen weeks. And every patient meets with a counselor to discuss all available options at a time that is very emotionally difficult.

Women's Health Specialists of Northern California (CA)

Women's Health Specialists is a living symbol of women's freedom and self-determination. Founded in 1975 by nine women as the Feminist Women's Health Center in Chico, California, Women's Health Specialists was established to advocate, promote and protect reproductive rights for all women. Our philosophy is that sharing information is the key to giving women control over their own gynecological health and reproductive choices. We believe all women have the right to choose when, if, and under what circumstances they will have children. Long-term social change is our priority, and our challenge, and we have expanded the meaning of women's health to its natural outcome: human rights. We are pioneers in the women's health movement; we created women-centered health care and developed and promoted safer medical techniques that have raised the standard of care in the United States, and we currently provide a full range of health care services, including birth control and abortion services in California.

III. Additional Organizations

Asian Communities for Reproductive Justice

Asian Communities for Reproductive Justice is a non-profit social, political, and economic justice organization in

Oakland, California, working for the liberation of Asian women and girls through the lens of reproductive justice. ACRJ promotes and protects reproductive justice through organizing, building leadership capacity, developing alliances, and education, to achieve community and systematic change.

Backline

Founded in 2004 and based in Portland, Oregon, Backline is a nonprofit organization dedicated to conversation around all aspects of pregnancy, parenting, abortion, and adoption. Through our nationwide talk-line, we speak to women and their loved ones every day who are making individual choices around these issues. We understand the uniqueness of every woman's story while recognizing the universality of the pregnancy experience.

Family Planning Advocates of New York State, Inc.

Family Planning Advocates of New York State (FPA) was founded in 1977 to ensure women's access to reproductive health care. FPA strives to advance public policies that fulfill the rights of individuals to comprehensive sexual and reproductive health services and education that is consistent with principles of justice and fairness, while respecting diversity, personal dignity, and privacy.

Feminist Majority Foundation

The Feminist Majority Foundation (the Foundation) is a nonprofit organization with offices in Arlington, Virginia, and Los Angeles, California. Dedicated to eliminating sex

discrimination and to the promotion of equality, women's rights, and safe access to abortion and birth control, the Foundation actively pursues legal protection for reproductive health services, and regularly works with 587 women's health care clinics and abortion providers across the country. The Foundation has led legal and advocacy efforts to maintain access to abortion and reproductive health care services in the face of unnecessary regulations and restrictive legislations, and intimidation and violence by anti-abortion extremists.

Hawaii State Coalition Against Domestic Violence

The Hawaii State Coalition Against Domestic Violence (HSCADV) was founded in 1980. Our mission is to ensure the safety and protection of women in intimate relationships by coordinating domestic violence prevention and intervention services, affecting public policy, and establishing coordinated and consistent procedures and actions by the civil and criminal justice systems in Hawaii. In keeping with our overriding goal of empowering women, the HSCADV supports a woman's right to reproductive freedom under all circumstances.

Iowa Coalition Against Sexual Assault

The Iowa Coalition Against Sexual Assault (CASA) is a membership organization of Iowa's twenty eight sexual assault crisis centers. Iowa CASA unites people and organization to promote a society free from sexual violence and to meet the diverse needs of survivors of sexual assault. Our experience assisting rape survivors for nearly twenty-five years confirms that women and girls do

become pregnant and do choose to terminate those pregnancies that result from rape and incest. We support the right of those survivors of sexual assault to choose the option that they determine to be in the best interest of themselves and their families.

Ipas

Ipas is an international nonprofit organization that has worked for three decades to increase women's ability to exercise their sexual and reproductive rights, and to reduce deaths and injuries of women from unsafe abortion. Ipas's global and country programs include training, research, advocacy, distribution of equipment and supplies for reproductive health care, and information dissemination.

Judicial Consent for Minors Lawyer Referral Panel

The Judicial Consent for Minors Lawyer Referral Panel (the Panel) is an association of Massachusetts attorneys who represent minors seeking judicial consent for an abortion under Massachusetts law. The Panel was created in 1981 by members of the Women's Bar Association of Massachusetts and the National Lawyers Guild, Massachusetts Chapter. The Panel is run by a Steering committee which has trained hundreds of attorneys in Massachusetts to represent young women in judicial bypass proceedings, as well as organizing and participating in trainings in many other states. They have also offered technical assistance to court systems implementing such laws, testified on the implementation of such laws in legislatures across the country and as expert witnesses in

litigation involving such laws, participated in research and written law review articles on the issue. Over the past twenty-five years, Steering Committee members collectively have represented thousands of young women.

National Latina Institute for Reproductive Health

The mission of the National Latina Institute for Reproductive Health (NLIRH) is to ensure the fundamental human right to reproductive health care for Latinas, their families, and their communities. Through advocacy, community mobilization, and public education, NLIRH is shaping public policy, cultivating new Latina leadership, and broadening the reproductive health and rights movement to reflect the unique needs of Latinas.

National Network of Abortion Funds

The National Network of Abortion Funds (NNAF) is a nonprofit reproductive rights organization with offices in Boston, Massachusetts. Founded in 1993, NNAF is an affiliation of 110 grassroots abortion funds located in forty-two states and the District of Columbia. NNAF's mission is to 1) promote direct financial support for abortions to low-income women and girls nationwide; and 2) conduct grassroots and national organizing, advocacy, public education, and policy work to ensure that those most in need – low-income women, women of color, and young women – have access to abortion and other reproductive health care.

Pennsylvania Coalition Against Domestic Violence

Pennsylvania Coalition Against Domestic Violence, Inc. (PCADV) is a not-for-profit organization incorporated in the Commonwealth of Pennsylvania for the purpose of providing services and advocacy on behalf of victims of domestic violence and their minor children. PCADV is a membership organization of sixty-two shelters, hotlines, counseling programs, safe home networks, legal advocacy projects, and transitional housing projects for battered women and their dependent children in the Commonwealth. For thirty years, PCADV has provided training and technical assistance to domestic violence programs, attorneys, the courts, and law enforcement agencies on issues of domestic violence.

ProKanDo

ProKanDo is a pro-choice, pro-woman organization based in the state of Kansas. ProKanDo works to identify, educate, and motivate pro-choice voters. ProKanDo lobbies the state legislature in support of bills that protect the reproductive rights of women, while working to defeat any harmful legislation that would turn back the clock on women's rights.

SisterSong Women of Color Reproductive Health Collective

SisterSong is a national network of seventy-six women of color and allied organizations that sustains, organizes, and mobilizes women of color working together on reproductive justice issues in the U.S.

Women's Bar Association of Massachusetts

The Women's Bar Association of Massachusetts (WBA) is a professional association of over 1,200 attorneys, judges, and elected officials dedicated to advancing and protecting the interests of women and children in society and in the practice of law. The WBA has been active in advocating for women and girls on reproductive issues for over twenty-five years, and has submitted amicus briefs in both federal and state matters involving reproductive choice and abortion.

Women Lawyers Association of Los Angeles (WLALA)

Women Lawyers Association of Los Angeles (WLALA) is a nonprofit organization comprised primarily of attorneys and judges in Los Angeles County. Founded in 1919, WLALA is dedicated to promoting the full participation of women lawyers and judges in the legal profession, maintaining the integrity of our legal system by advocating principles of fairness and equality, and improving the status of women in our society. WLALA places a high priority on preserving personal choice in abortion decisions.

Women's Health and Family Planning Association of Texas

The Women's Health and Family Planning Association of Texas (WHFPT) is a professional association and nonprofit organization whose mission is to advocate for access to affordable, confidential, and high-quality family planning and reproductive health care for all Texas women and their families. WHFPT works to ensure that family planning

services are funded through public sources; that reproductive freedoms are protected; that sexuality education is medically accurate, age appropriate, and complete (and includes information about contraceptives); and that laws, rules, and regulations do not limit access to needed and desired reproductive health care and family planning services. WHFPT's members include health departments, medical schools, Planned Parenthood affiliates, community action agencies, hospitals and hospital districts, community health centers, other nonprofit clinics, and interested and committed individuals.

Women's Reproductive Rights Assistance Project

The Women's Reproductive Rights Assistance Project is a nonprofit organization dedicated to funding low-income women and teens in need of abortion services or emergency contraception. We are a national fund and have been assisting women since 1991. Our services are provided free to the clinics on behalf of the women; all of the women we assist would be without their reproductive rights if we did not exist. Access to an abortion or emergency contraception depends on the ability to pay for the services, and without our help, many women would be forced to bring unplanned and unwanted pregnancies to term.

WV FREE (WV Focus: Reproductive Education and Equality)

WV FREE was founded in 1989 with a mission to protect the right to choose, increase accessibility to affordable birth control and prenatal care, and improve education on

reproductive choices. Because we value women's health and women's lives, we view access to reproductive health care as a basic human right. WV FREE provides legislative advocacy on women's reproductive health concerns, conducts public education campaigns on family planning issues, and works to address the abortion provider shortage in West Virginia. To reduce the high rate of unintended pregnancies and the often-resultant need for abortion services, we are currently engaged in cutting-edge emergency contraception access work.

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IN THE
SUPREME COURT OF THE UNITED STATES

ALBERTO R. GONZALES, ATTORNEY GENERAL
OF THE UNITED STATES, *Petitioner*

v.

PLANNED PARENTHOOD FEDERATION
OF AMERICA, ET AL., *Respondents*

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

AMICUS CURIAE BRIEF BY LEGAL DEFENSE FOR UNBORN CHILDREN IN SUPPORT OF NEITHER PARTY

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INTEREST OF THE AMICUS CURIAE

The *amicus* defends the constitutional right to life of unborn children which the parties have not done.

SUMMARY OF ARGUMENT

The U.S. Constitution's guarantee of life to "any person," made in its 5th and 14th Amendments, does include the unborn.

ARGUMENT

I.

THE U.S. CONSTITUTION'S GUARANTEE OF LIFE TO "ANY PERSON" DOES INCLUDE THE UNBORN.

The Declaration of Independence announced that reverence for life is America's founding principle. It said that all men are created equal, all are endowed by their Creator with an unalienable right to life, and the purpose of government is to protect the life of everyone.

America told the world that if we will follow our reverence for life wherever it may lead, then a future of more abundant life, which we can look forward to with hope, will unfold before us. On the other hand, Madison warned that the primitive idea, that some can gain by harming others, had ruined all democracies known to history.[1] And the lethal inventions of science have made reverence for life the only way to the future.

A. On its Face, the U.S. Constitution's Guarantee of Life to "Any Person" Does Include the Unborn

This guarantee of life to everyone was incorporated into the U.S. Constitution. The 14th Amendment's guarantee of life reads: "(N)or shall any State deprive ***any person*** of

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[1] *The Federalist*, No. 10 (James Madison).

Rule 37.6 disclosure: Counsel authored the whole *amicus* brief; no monetary contributors are required to be identified.

life...without due process of law." (emphasis added).

The words "any person" are universal, admit of no exceptions for anyone, make no distinction between born and unborn life, and on their face include the unborn, the same as everyone else. The obvious purpose of guaranteeing life universally to "any person" was to prohibit government officials making exceptions so some persons could be exterminated.

The Court admitted that if the word "person" included the unborn, then *Roe* v. *Wade* "collapses," because the lives of the unborn would be "guaranteed" by the Constitution.[2] But the Court implied that "the word 'person,' as used in the Fourteenth Amendment, does not include the unborn."[3] Thus the Court hit the Constitution head-on, directly defied its express prohibition of extermination, and condemned to death those victims whom the Constitution, by its plain words, endeavors to preserve.

The words "any person" are the two most important words ever written into law because they protect the lives of everybody from extermination, and they summarize America's unique contribution to civilization. As Lincoln said, what made America great was the promise "that ***all*** should have an equal chance."[4] (emphasis in text).

The words "any person" are the words which guarantee that equal chance to live to ***all***, they stand as the supreme political achievement of the human race, the prize of millenniums of struggle. If the Constitution had stated it protected the life of "any person - except the unborn," then its words would support *Roe* v. *Wade*. But its words say "any person," without any exceptions.

The Court ruled that the words "any person" included

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[2] *Roe* v. *Wade*, 410 U.S. 113, 156-157 (1973).

[3] *Id.*, at 158.

[4] 4 *Collected Works of Abraham Lincoln* 240 (R. Basler ed. 1953).

Chinese aliens, merely saying the words are "universal in their application, to all persons...without regard to any differences." *Yick Wo* v. *Hopkins*, 118 U.S. 356, 369 (1886).

In 1975, the Supreme Court of West Germany held that the words in its Constitution, "Everybody has the right to life," did include the unborn. It explained that the word "everybody" is universal.

But in *Roe* v. *Wade*, the Court ignored the letter of the law. Instead the Court focused on the isolated word "person," and ignored its modifier "any." Yet "any" is the word which means "all," and extends the right to life to everyone without any exceptions.

By reading the universal guarantee of life to "any person" as if it were merely a guarantee to "some persons," the Court did the most forbidden thing, and reduced the most important law in history to nothing.

The Constitution extends its guarantee of life to "any person." The letter of the law permits no exceptions. On their face the universal words "any person" do include the unborn.

B. The Spirit of the Law Proves that the U.S. Constitution's Guarantee of Life to "Any Person" Does Include the Unborn

Roe v. *Wade* violates the spirit of the law, as well as its letter. The Court itself ruled that the Declaration of Independence is the spirit of the Constitution:

> The first official action of this nation declared the foundation of government in these words: "We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable rights, that among these are life..." While such declaration of principles may not have the force of organic law...yet the latter is but the body and the letter of which the former is the thought and the spirit, and it is always safe to read the letter of the Constitution in the spirit of

> the Declaration of Independence. No duty rests more imperatively upon the courts than...to secure the equality of rights which is the foundation of free government.
> *Gulf, Colo. & S. Ry* v. *Ellis*, 165 U.S. at 159-160 (1896).

There is no real medical dispute that the unborn have been created and are alive.[5] So reading the letter of the Constitution, the universal guarantee of life to "any person," in the spirit that ***all*** are "created equal," and ***all*** shall get their chance to live, permits only one conclusion - that the words "any person" do include the unborn.

C. History Confirms that the Constitution's Guarantee of Life to "Any Person" Does Include the Unborn

In addition to the letter and spirit of the law, the universal embrace of this guarantee of life to "any person" is also evident from its history. The last time the Court implied an exception to the words "any person" was *Dred Scott* v. *Sandford*, 19 How. 393 (1857). There the Court ruled that: the word "person," as used in the Fifth Amendment, did not include Negroes because they were not persons in the whole sense; the phrase in the Declaration of Independence, "all men are created equal," did not include Negroes; there was a constitutional right to own a slave ("the right of property in a slave is distinctly and expressly affirmed in the Constitution"); Congress could not prohibit slavery in the territories; people were free to choose whether or not to own slaves; and Negroes could not sue in federal courts to see if they were slave or free.

Abraham Lincoln opposed the *Dred Scott* decision. If officials can say all men are created equal except Negroes, he

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[5] The medical evidence in the Texas brief in *Roe v. Wade* showed the fetal heart begins "pulsations at 24 days," and "brain waves have been noted at 43 days," and the unborn child is "alive."

asked, "where will it stop?"[6] If officials can say the Declaration does not include blacks, Lincoln argued that they can say it doesn't include any other person. He claimed *Dred Scott* was based on "falsehood."[7] He alleged a conspiracy by the U.S. Supreme Court, two U.S. Presidents, and leading members of Congress to overturn the U.S. Constitution and impose a slave empire on America.[8]

Lincoln said he would not obey *Dred Scott*. Citing both Thomas Jefferson and Andrew Jackson as authority,[9] he said the president swears an oath to obey the Constitution as he understands it, and not as it was understood by the Supreme Court. If the president were bound by *Dred Scott*, Lincoln explained in his First Inaugural Address, "the people will have ceased, to be their own rulers."[10]

Dred Scott triggered a civil war. Various States withdrew from the Union rather than be deprived of their constitutional right to own a slave, as decreed by the Court. President Lincoln defied the Court's *Dred Scott* decision, that there was a constitutional right to own a slave, because he emancipated the slaves and declared them to be "forever free."[11] He reminded us at Gettysburg that we were fighting to see whether a nation dedicated to the proposition that "all men are created equal" could long endure.

One of the framers of 14th Amendment explained that its purpose was to rededicate America to its original proposition: "It establishes equality before the law, and it gives to the humblest...the most despised...the same protection before the law as it gives to the most powerful....Without this...there is no republican government." Rep. Jacob Howard, quoted in

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[6] 2 *Collected Works of Abraham Lincoln* 500 (R. Basler ed. 1953).
[7] *Id.*, 495.
[8] *Id.*, at 461-469, 521.
[9] *Id.*, at 402, 516-17.
[10] 4 *Collected Works of Abraham Lincoln* 268 (R. Balser ed. 1953).
[11] 6 *Collected Works of Abraham Lincoln* 28-30 (R. Balser ed. 1953).

B. Schwartz, 1 *Statutory History of the United States: Civil Rights* 262 (1970).

The framers of the Fourteenth Amendment learned from *Dred Scott*. They said the Supreme Court must never again imply exceptions to the words "any person." They employed the universal words most suited for this purpose.

And by the middle of the 19th century, medical science had discovered that an unborn child was alive throughout gestation, and there was no time during gestation when science could draw a line and say the unborn were not alive. By the time the Fourteenth Amendment was adopted in 1868, the vast majority of States had already enacted criminal abortion laws to protect all stages of unborn life, and within a few years such laws were universal.

The history of these criminal abortion laws shows that the framers and adopters of the Fourteenth Amendment intended its universal guarantee of life to "any person" to mean what it says, and to include the unborn the same as everyone else.

Yet *Roe* v. *Wade* is another *Dred Scott* disaster. The Court assumes that, without one word of explanation, the framers intended their guarantee of life to "any person" to sweep away all their abortion statutes and make the killings, which they said were criminal, into "liberty." The Court assumes that the framers connived to repudiate a major point of the Civil War, so judges would again be at liberty, as in *Dred Scott*, to convulse society by implying more exceptions to the words "any person." And the Court amends the Declaration of Independence to read "all men are created equal - except those created to be killed." The Court claims it can decree who was created to be killed.

The Court did the most forbidden thing: it directly defied the Constitution's express guarantee of life to "any person," and decreed criminal extermination to be legal.

The Fourteenth Amendment's letter, spirit, and history allow only one conclusion: the express and universal guarantee of life to "any person" does include the unborn.

II.

ROE v. *WADE* IS VOID BECAUSE IT CRIMINALLY DEFIED THE CONSTITUTION'S GUARANTEE OF LIFE TO "ANY PERSON" AND CONDEMNED TO DEATH MILLIONS OF VICTIMS WHOM THE CONSTITUTION ENDEAVORS TO PRESERVE.

A.

Roe v. Wade Criminally Defied the Constitution's Guarantee of Life to "Any Person" Because the Court Decreed Killings to Be "Liberty" Which the People Had Defined to Be "Murder." In Effect, the Court Decreed MASS MURDER IS LIBERTY.

When *Roe* v. *Wade* was decided in 1973, an abortion was murder if the child was "born alive." A child could be "born alive" during second or third trimester abortions. Indeed, the State of Georgia forewarned the Court that certain abortions were "murder."[12] But the Court scorned that warning and decreed those very killings to be "liberty."[13]

In 1976, a physician explained to Congress that *Roe* v. *Wade* permitted second trimester hysterotomy abortions, and children killed by this abortion procedure can be "born alive":

> "With few exceptions, babies aborted by this method will all move, will all breathe, and some will cry.... Almost all were **born alive**."[14] (emphasis added)

The physician showed Congress this photograph of a child

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[12] *Doe* v. *Bolton*, 410 U.S. 179 (1973), Brief for Appellees 52-53.

[13] *Roe* v. *Wade*, 410 U.S. 113, 153 (1973). The Court decreed a right to abortion to be "founded in the Fourteenth Amendment's concept of personal liberty."

[14] Hearings on Constitutional Amendments on Abortion, before subcomm. On Civil and Constitutional Rights, of the House Comm. Of the Judiciary, 94th Cong., 2d Session, Ser. 46, Part 1 at 397 (1976).

killed by a salt poisoning abortion. He said this method could also result in a child being "born still alive."

For almost four centuries, Americans had defined such killings to be "murder." But in 1973 the Court decreed such killings to be "liberty."

And by 1973, States had decided that in the third trimester a child need not be "born alive," but was a human being within their homicide or murder statutes if the child were killed "in the process of being born."[15] But the Court also decreed those murders to be "liberty."[16] Indeed under *Roe* v. *Wade* doctors kill children in the very process of being born.

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[15] *People* v. *Chavez*, 77 Cal. App. 2d 621, 626 (1947).

[16] *Doe* v. *Bolton*, 410 U.S. 179 (1973). The Court decreed that abortions could be performed in the third trimester to protect the woman's "health," which the Court ruled included "all factors - physical, emotional, psychological, familial, and the woman's age - relevant to the well being of the patient." In effect, this too is abortion on demand.

1. The Court Decreed Killings to Be "Liberty" Which Americans Had Condemned as "Murder" Since Earliest Colonial Times.

America's first settlement at Jamestown followed the English common law, as did other colonies. The common law defined an abortion, in which a "quick" (about 4 months gestation) child died after being "born alive," to be "murder."[17] Even if not yet viable, if the child was "born alive," Coke (the standard 17th century legal authority) condemned the abortion as "so horrible an offense" and "this is murder."[18] Jefferson wrote that Coke's work was "the fundamental code of English law"[19] which makes it a foundation of American liberty.

The English writers cited this as the correct statement of the law.[20] And English courts followed this law.[21]

The English common law was the law of the land in colonial America. By allowing second and third trimester abortions, the Court decreed killings to be "liberty" which Americans had defined to be "murder" since earliest colonial times.

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[17] Coke, 3 *Inst.* 50; Hawkins, 1 *Hawkins* Ch. 13, s. 16; Blackstone, 4 *Bl. Com.* 198.

[18] Coke, 3 *Institutes* 50.

[19] Jefferson wrote of Coke's *Institutes*: "This work is executed with so much learning and judgment, that I do not recollect that a single position in it has ever been judicially denied....It may still be considered as the fundamental code of English law." Thomas Jefferson, 14 *Writings of Thomas Jefferson* 57 (1907). Jefferson served on the 1776 committee which adapted Virginia's laws to republican form, the common law being assigned to him.

[20] J.F. Archbold, 1 *Complete Treatise on Criminal Procedure, Pleading and Evidence* 783 (Waterman Am. Ed. 7th ed. 1860); W.O. Russell, 1 *Treatise on Crimes and Misdemeanors* 671-672 (4th ed. 1865).

[21] *Regina* v. *West*, 2 C & K 784 (1848).

2. The Court Decreed Killings to Be "Liberty" which the Framers and Adopters of the Fourteenth Amendment Had Defined to Be "Murder."

The English common law is the dictionary which American courts use to construe the state and federal homicide statutes.[22]

By the time the Fourteenth Amendment was adopted in 1868, American legal authorities and State supreme courts had long followed the common law rule that second and third trimester abortions were murder if the child were born alive. And viability was irrelevant. If death were caused by the child being too immature to survive outside the womb, the abortion was murder.

In 1859 the American Medical Association reported the law of murder which existed throughout the United States:

> If a person, intending to procure abortion, does an act which causes the child to be born earlier than its natural time, and therefore in a state much less capable of living, and it afterwards die in consequence of such premature exposure, the person who by this misconduct brings the child into the world, and puts it into a situation in which it cannot live, is guilty of ***murder***.[23] (emphasis added).

This was the uncontradicted view in the United States when the Fourteenth Amendment was adopted.[24] This definition of murder was approved by the preeminent legal

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[22] *Clarke* v. *State*, 117 Ala. 1 (1898); *Hamilton* v. *United States*, 26 App. D.C. 382 (1905).

[23] Reported in A. S. Taylor, *A Manual of Medical Jurisprudence* 462 (6th ed. 1866). He described the AMA report as "a complete and comprehensive exhibit of laws of each of the United States." Id., at 460.

[24] J. P. Bishop, 2 *Commentaries on the Criminal Law* 365 (4th ed. 1868); A. S. Taylor, *supra* note 23, at 462, 517 (1866).

writers of the 19th century,[25] and it was adopted by State supreme courts.[26] It was still the law in 1973.[27] In 1975 the New Jersey courts applied this law of murder to an unviable fetus born alive:

> That a fetus may be the victim of murder if it be born alive has long been a part of our common law....Coke, *Institutes* 58 (1648).[28]

For almost four centuries governments came and went in America, but this law of murder endured as the law of the land. And it is binding on the U.S. Supreme Court.[29]

Yet the Court ruled that States could not protect unborn life until the third trimester which the Court set at viability- "about 7 months."[30] But in effect (due to the Court's definition of the mother's "health") States could not protect unborn life anytime prior to actual birth. Thus the Court decreed both second and third trimester abortions to be "liberty" which the framers and adopters of the Fourteenth Amendment had defined to be "murder."

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[25] F. Wharton, *A Treatise on the Law of Homicide in the United States* 93 (1855); Bishop, *supra* note 24; Taylor, *supra* note.23.

[26] *Clarke* v. *State*, 117 Ala. 1 (1898); *Watson* v. *State*, 117 A 2d 549 (1955); *Porter* v. *Lassiter*, 87 S. E. 2d 100 (1955); *People* v. *Chavez* 176 P. 2d 92 (1947); *Bennett* v. *State*, 377 P.2d 634 (1947); *Singleton* v. *State*, 35 So. 2d 375 (1948).

[27] 2 L. Burdick, *The Law of Crime* 156 (1946); 1 *Wharton's Criminal Law and Procedure* 434 (12th ed. 1957); R. Perkins, *Criminal Law* 30 (2d ed. 1969).

[28] *State* v. *Anderson*, 343 A. 2d 505, 508 (1975), aff'd 413A.2d 611 (1980). The court rejected the claim it was not murder because "the infants were never capable of maintaining a separate and independent existence." *Id.* at 615.

[29] The Court must accept the construction given by a state to its own statute. *Pollard* v. *Dwight*, 4 Cranch 421, 429.

[30] *Roe* v. *Wade*, supra, 160, 163.

3. The U.S. Supreme Court and the U.S. Government Claim Power to Decree the Mass Murder of Jews, or Anyone Else, to Be Liberty.

Of course, if the U.S. Supreme Court can decree the mass murder of some persons to be liberty, then it can decree the mass murder of anybody to be liberty.

Indeed, when the U.S. Supreme Court was accused of mass murder in the U.S. District Courts, the U.S. Government defended its Justices by expressly claiming that its Supreme Court must be obeyed even if it decreed the mass murder of Jews, or anyone else, to be liberty. An incredulous U.S. District Judge asked the U.S. Government:

> **[U.S. District Judge]: Let me ask you to respond to this question. The plaintiff argues in his brief that the Supreme Court in *Roe v. Wade* took a discrete group of entities and said that these entities have no right to live, and thus may be killed .... And he said if you take *Roe v. Wade* and remove the word "fetus" and just substitute most any other word you want of another discrete group, that we wouldn't be here discussing this at all. Let's say that instead of "fetus," they said "Jews." That is the one he used in his brief.**
>
> **Would you argue stare decisis to me if,under Roe v. Wade, at the whim of neighbors Jews could be put to death?**
>
> **[U.S. Govt. Lawyer]: (I) would have to agree with the doctrine of stare decisis and advance it to the court.**[31]

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[31] *Ernest* v. *U.S. Attorney for the Eastern District of Virginia and U.S. Attorney General*, U.S. District Court in Richmond, Civ. No. 84-0858, transcript of proceedings at 21-22. This complaint attacked the validity of *Roe* v. *Wade* on the grounds that the U.S. Supreme Court cannot lawfully decree mass murder to be liberty. It demanded that the District

As victims were being killed in defiance of murder statutes, the U.S. District Judge adopted the U.S. Government's claim that he must obey the U.S. Supreme Court even if it decreed the mass murder of Jews, or anyone else, to be liberty. And on review, not one Justice had any objection to this ruling.[32]

And the Justices were accused of mass murder in a U.S. District Court on the grounds they cannot lawfully decree mass murder to be liberty. Each Justice defended himself or herself by claiming all lower courts must obey the U.S. Supreme Court "no matter how misguided" its decrees may appear to be.[33]

Thus both the U.S. Government and its U.S. Supreme Court maintain the killings by officially claiming the power to decree the mass murder of Jews, or anyone else, to be liberty.

4. The U.S. Supreme Court Has Committed Treason to the U.S. Constitution.

Chief Justice John Marshall would have called *Roe* v. *Wade* "treason to the Constitution." In *Marbury* v. *Madison*, he wrote that the purpose of the Constitution was to control the government, including judges, and the intention of its framers is the law.[34] He later ruled that the Court could not extend the Constitution "to objects not...contemplated by its framers."[35] And Marshall warned that if the Court usurped

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Judge refuse to obey *Roe* v. *Wade*.

[32] *Ernest* v. *U.S. Attorney for the Eastern District of Virginia, and U.S. Attorney General*, cert. Denied 475 U.S. 1084 (1986).

[33] *Ernest* v. *Rehnquist, Stevens, Breyer, O'Connor, Scalia, Kennedy, Souter, Thomas, Ginsburg, etc., U.S. Attorney, etc., U.S. Attorney General*, et al, U.S. District Court in Alexandria, Civil No. 89-732-A, Defendants' *Motion to Dismiss*, page 3. The District Court adopted this argument as law by summary decree, refusing to even allow a hearing.

[34] *Marbury* v. *Madison* at 176-180 (1803).

[35] *Ogden* v. *Saunders*, 12 Wheat. at 332 (1827).

such power, it would be "treason to the Constitution."[36]

The officials to be controlled are not free to invent a constitution more to their liking. Lawless officials can overthrow a constitution as surely as armed rebels. Indeed President George Washington warned that "change by usurpation" was "the customary weapon by which free governments are destroyed."[37]

By decreeing killings to be "liberty" which the framers had defined to be "murder," the Court exactly extended the Constitution to objects not contemplated by its framers. The Court confronts the nation with the boldest and plainest case of officials committing "treason to the Constitution."

By merely changing the names of the victims being killed, the U.S. Supreme Court has duplicated the decree of "the supreme judge" of Nazi Germany. At Nuremberg the Nazi judges claimed they could not be prosecuted for complicity in extermination and murder because "the supreme judge" had decreed the killing of Jews and other minorities to be legal, and they were obligated to obey the decrees of their supreme judge.[38] But the United States prosecuted Nazi judges for obeying their supreme judge.

Now U.S. officials conspire to impose the same Nazi doctrines on the United States which the United States itself prosecuted as extermination and murder at Nuremberg. This

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[36] *Cohens* v. *Virginia*, 6 Wheat. at 404 (1821).

[37] George Washington, 35 *The Writings of George Washington* 229 (Fitzpatrick ed. 1940). (Washington's Farewell Address)

[38] *United States* v. *Altstoetter*, 3 Trials of War Criminals Before the Nuernberg Military Tribunals 1011-1014 (1951). Hitler claimed the emergency provisions of the Weimar Constitution gave him power to act as "the supreme judge." As such he decreed the killing of Jews and other minorities to be legal. Nazi judges claimed they could not be held accountable for complicity in extermination and murder, since they had acted "within the authority" of the "decrees" of "the supreme judge." *Id.* at 983-85. But the Tribunal rejected that defense: "The dagger of the assassin was concealed beneath the robe of the jurist." *Id.*, at 985.

Court claims power to decree the mass murder of Jews, or anyone else, to be legal; and government officials claim they must obey such decrees.

America has surrendered the promise that everybody has an unalienable right to life and the purpose of government is to protect the life of everyone. Now the lives of all Americans depend on the whim of government officials, as in Stalin's Russia or Hitler's Germany.

When U.S. Officials conspire to impose Nazi doctrines on the United States, then no honest person can doubt that these officials have committed treason to the U.S. Constitution.

5. The United States Being Ruled By a Giant Conspiracy to Mass Murder Is the Most Catastrophic Crime in the History of Civilization.

But if U.S. Officials cannot lawfully decree mass murder to be liberty, then the United States is now being ruled by a giant conspiracy to mass murder - a conspiracy by the leading U.S. Officials to kill children in defiance of murder statutes.

America introduced civilization to the idea that reverence for life is the future for the world. Yet America is now ruled by the most corrupt decree which the human mind can even imagine - MASS MURDER IS LIBERTY. And government is reduced to the mere matter of which mass murderer can grab power, issue orders, and be blindly obeyed.

The U.S. Government knows how to make atomic bombs, but it does not know the difference between mass murder and liberty. This is the vision which America now holds out to guide the future of the world. Now we all descend into a terrifying darkness.

B.

Roe v. Wade Criminally Defied the Constitution's Guarantee of Life to "Any Person" Because the Court Defied the Rulings of John Marshall and Used a "Guilty Until Proven Innocent" Burden of Proof to Imply that the Words "Any Person" Do Not Include the Unborn.

The Court used the correct burden of proof when it previously construed these universal words "any person."[39] Yet in *Roe* v. *Wade*, the Court actually reversed the burdens.

1.

Chief Justice John Marshall explained what the Court must prove in order to imply an exception to express and universal terms in the U.S. Constitution.

As already described, the words "any person" are express and universal, and on their face include the unborn, the same as everybody else. In order to imply an exception to exclude the unborn from the universal guarantee of life, so they can be killed with impunity from criminal laws, the Court must prove that including the unborn within the terms "any person" would be "so monstrous, that all mankind would, without hesitation, unite in rejecting the application."[40]

And the Court must prove that if the right to life of the unborn had "been suggested [to the framers] the language would have been so varied, as to exclude it."[41] The Court

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[39] The Court ruled the words "any person" included Chinese aliens ("subjects of the emperor of China") merely saying the words are "universal." *Yick Wo* v. *Hopkins*, 118 U.S. 356, 369 (1886).

And the Court was so sure that the words "any person" included "corporations" it refused to allow counsel to argue against it. *Santa Clara* v. *So. Pac. RR*, 118 U.S. 394, 396 (1886).

[40] *Sturges* v. *Crowninshield*, 4 Wheat. 122, 202-203 (1819). When the Constitution uses universal words, and a case is "within the very words of the Constitution," the Court may not infer an exception unless the "absurdity and injustice of applying the provision to the case, would be so monstrous, that all mankind would, without hesitation, unite in rejecting the application."

[41] *Dartmouth College* v. *Woodward*, 4 Wheat. 518, 644-45 (1819). When the Constitution uses universal words, " It is not enough to say that this particular case was not in the mind of the Convention, when the article was framed, nor of the American people, when it was adopted. It is necessary to go farther, and to say that, had this particular case been suggested, the language would have been so varied, as to exclude it, or it would have been made a special exception."

must prove that the framers would have changed the Fourteenth Amendment to read: "Nor shall any State deprive any person, **except unborn persons**, of life without due process of law."

These are the burdens which protect the lives of all Americans from government sanctioned extermination, as happened in Hitler's Germany, or Stalin's Russia. Obviously, the Court must bear the heaviest burden of proof in order to imply an exception to the Constitution's guarantee of life to "any person" so millions of victims can be killed with impunity from criminal statutes.

Under Chief Justice Marshall's rules, the Constitution's guarantee of life to "any person" does include the unborn because "all mankind" would not unite "without hesitation" to exclude the unborn. And the framers of the Fourteenth Amendment would not have changed its guarantee of life to read "any person - except the unborn." The framers and adopters had already enacted criminal statutes to protect the lives of the unborn throughout gestation, and some abortions were murder. Thus there is no doubt that this universal guarantee of life to "any person" does include the unborn.

2.

But in *Roe v. Wade* the Court exactly reversed the burdens of proof described by Chief Justice John Marshall. The Court said that the evidence did not prove "with any ***assurance***"[42] that the guarantee of life to "any person" included the unborn. Assurance means "To make certain and put beyond doubt."[43]

First, the Court assumed that the words "any person" did not include the unborn, and then it placed the burden on the unborn to prove with "assurance," to prove beyond doubt, that the words "any person" did include the unborn.

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[42] *Roe* v. *Wade*, 410 U.S. at 157. (emphasis added).

[43] *Black's Law Dictionary* (4th ed. 1968).

Thus the Court made the legitimacy of *Roe* v. *Wade* rest on doubt. It presumed that doubts about the legality of the killings created a constitutional right to kill. Somehow confusion about the right to kill creates the right to kill.

When courts use this burden of proof to condemn tens of millions of victims to death, Americans can not pretend they still have a government of Constitution and laws.

The Court claims it can use this burden of proof to decree the extermination of anyone to be liberty.

C.

Roe v. _Wade_ Criminally Defied the Constitution's Guarantee of Life to "Any Person" Because The Court Used Criminal Procedures to Conclude that the Words "Any Person" Do Not Include the Unborn.

Roe v. Wade was a mock trial designed to exclude truth.

And the Court maintains its killings with mock trials. It refuses to allow counsel to represent the unborn and defend their right to life. It refuses to allow its false evidence in *Roe v. Wade*, which it used to imply that the words "any person" did not include the unborn, to be confronted and cross-examined. It refuses to allow evidence to be presented to show the Constitution's guarantee of life to "any person" does include the unborn.[44]

D.

Roe v. _Wade_ Criminally Defied the Constitution's Guarantee of Life to "Any Person" Because the Court Fabricated False Evidence to Conclude that the Words "Any Person" Do Not Include the Unborn.

The history of the criminal abortion statutes proves that the

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[44] The *Motion to Allow Counsel to Represent Children Unborn and Born Alive* (filed in this case, and incorporated by reference) describes the Court's procedures.

framers of the Fourteenth Amendment did not intend its guarantee of life to "any person" to exclude the unborn.

When the Amendment was adopted in 1868, over three-fourths of the ratifying States had already enacted statutes which made abortion at any stage of gestation a crime.[45] Within a few years, these criminal statutes were universal.

The ancient common law supposed that life commenced at "quickening" - when the mother felt the child stir in her womb. But judicial revision makes it impossible for the Court to assert with assurance that the common law in 1868 was any different than the abortion statutes supplanting it. As one Court observed:

> By the ancient common law...as the life of an infant was not supposed to begin until it stirred in the mother's womb, it was not regarded as a criminal offense to commit an abortion in the early stages of pregnancy. A considerable change in the law has taken place in many jurisdictions by the silent and steady progress of judicial opinion; and it has been frequently held by Courts of high character that abortion is a crime at common law without regard to the stage of gestation.[46]

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[45] The statutes are set out in Quay, *Justifiable Abortion, Medical and Legal Foundations*, 49 Geo. L. J. 447-520 (1961).

[46] *Lamb* v. *State*, 67 Md. 524 (1887). Some state supreme courts ruled that the common law made abortion at any stage of gestation a crime. *Mills* v. *Comm.*, 13 Pa. 631 (1850); *State* v. *Slagle*, 83 N.C. 544 (1880); *State* v. *Reed*, 45 Ark. 333 (1885). And those state supreme courts which ruled that abortion prior to quickening was not a common law crime were immediately overruled by their legislatures which made abortion at any stage of pregnancy a crime. *Comm.* v. *Parker*, 50 Mass. 263 (1845), was immediately overruled by Mass. Acts & Resolves ch. 27 (1845). *State* v. *Cooper*, 22 N.J.L. 52 (1849), was immediately overruled by N.J. Laws at 266 (1849). *Abrahams* v. *Foshee*, 3 Iowa 274 (1856) was overruled by the next legislature, Iowa Rev. Laws, tit. XXIII, ch. 165. art. 2, sec. 4221 (1860).

By 1868, medical science had long rejected the ancient notion that life commenced at "quickening." The abortion statutes reflected the views of medical science that there was no time during gestation when the unborn were not alive.

In view of this history, the Court cannot meet its heavy burden to prove that the framers intended to exclude the unborn from the Fourteenth Amendment's guarantee of life to "any person," so they could be killed for convenience. This evidence is fatal to *Roe* v. *Wade*.

Thus the Court needed to rewrite 19th century medicine and law. The Court fabricated the hypothesis that the 19th century abortion statutes were intended to protect only the mothers, not the unborn. This suggested that the American people never intended the lives of the unborn to be protected by law. This hypothesis was fabricated as follows.

1.

The Court first asserted as fact, "When most criminal abortion laws were first enacted, the procedure was a hazardous one for the woman." *Roe* v. *Wade*, 410 U.S. at 148. The Court claimed that abortions, even by physicians, were hazardous to the woman.

The only authority the Court cited to prove its assertion was a 20th century medical history book.[47] But this book only described the hazards of major surgery in general prior to Lister's discovery of antiseptics. The abortion operation was not mentioned anywhere in the entire book.

The 19th century obstetric authorities throughout the Western world prove that abortions by physicians were "perfectly safe" to the woman.[48] The Court did not examine

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[47] Haagensen and Lloyd, *A Hundred Years of Medicine* 19 (1943), cited in *Roe v Wade*, 410 U.S. at 148 n.43.

[48] 2 T. Denman, M.D., *An Introduction to the Practice of Midwifery* 96 (1802). He was a standard English authority. A French physician wrote

even one of these obstetric textbooks. They prove the Court's assertion of fact, "the procedure was a hazardous one for the woman," to be false.

The Court never revealed the hazardous abortion procedure to which it was referring. Actually, the 19th century physicians generally used the ancient method,[49] which one physician traced back 2000 years,[50] and which they described as "perfectly safe" to the woman.

Since abortions by physicians were not hazardous to the mother, the only motivating purpose the abortion statutes could have had was to protect the lives of the unborn from destruction by abortions. Had it been the purpose of the legislators to only protect the mother, they would have simply required abortions to be performed by physicians.

2.

The Court next asserted as fact, "Abortion mortality was high."[51] The Court cited no authority to support it.

The Court intended this assertion to prove that physicians were killing so many women with abortions that women needed legislation to protect them from the medical profession.

"experience has proved that the dangers of the operation are reduced to a small matter." A.L.M. Velpeau, M.D., *A Complete Treatise on Midwifery* 530 (4th Am. ed. 1852). The preeminent American physician wrote "to the mother there is very little danger." H.L. Hodge, M.D., *The Principles and Practice of Obstetrics* 293 (1864).

[49] Dr. Denman, a standard authority in England, wrote in 1802: 'the membranes of the ovum are punctured," which permitted "the discharge of the waters," which induced the "action of the uterus," which resulted in the expulsion of the fetus from the womb, which was "perfectly safe" to the woman. 2 T. Denman, *An Introduction to the Practice of Midwifery* 96-99 (1802).

[50] F. Ramsbotham, M.D., *The Principles and Practice of Obstetric Medicine* 724 (4th ed. 1856).

[51] *Roe* v. *Wade*, 410 U.S. at 149.

The 19th century obstetric authorities prove this assertion to be false. The obstetric texts show that abortions by physicians were "perfectly safe" to women.

3.

The Court next asserted the conclusion it derived from these two false assertions of fact:

> "[A] State's real concern in enacting a criminal abortion law was to protect the pregnant woman, that is, to restrain her from submitting to a procedure that placed her life in serious jeopardy." *Roe v. Wade*, 410 U.S. at 149.

This is a false inference, drawn from two false assertions of fact.

The evidence shows these abortion statutes were intended to protect the unborn. The 19th century treatises on criminal law stated that the foetus was "a living being immediately after conception" and these abortion statutes were intended to protect the lives of the unborn during all stages of gestation.[52] And State supreme courts ruled that these abortion statutes protected the lives of the unborn.[53] And authors of the statutes said their purpose was to protect the unborn.[54]

An 1860 study by the American Medical Association contrasted the striking difference between safe abortions by physicians, and lethal abortions by criminals:

> "In thirty-four cases of criminal abortion ... twenty-two were followed... by death, and only twelve were not. In

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[52] 1 F. Wharton, *A Treatise on the Criminal Law of the United States* 656-57 (5th ed. 1861).

[53] *Smith* v. *State*, 33 Me 48 (1851).

[54] See quotes, *infra* pages 23-24, of Joynes, who authored the Virginia statute, and of the AMA, which proffered a model statute to the States.

fifteen cases necessarily induced by physicians, not one was fatal." H.R. Storer, M.D., *On Criminal Abortion in America* 43 (1860).

Since abortions by physicians were known all over the western world to be safe to women, the motivating purpose of these abortion statutes could only have been to protect the lives of unborn children from destruction by abortions. Since legislatures prohibited safe abortions by physicians, despite the great danger to the mother from abortions by criminals, it proves that their motivating concern was to protect unborn life.

4.

The Court then concluded, "the word 'person,' as used in the Fourteenth Amendment, does not include the unborn." *Roe* v. *Wade*, 410 U.S. at 158.

The Court could not find even one 19th century authority to support this result.

In view of these abortion statutes, the Court cannot prove that the people who framed and adopted the Fourteenth Amendment intended its guarantee of life to "any person" to exclude the unborn, so they could be killed for convenience.

5.

The Court resurrected the ancient view that life commenced at "quickening" (about four months gestation) and arbitrarily expanded that to "viability" (about seven months gestation). Yet, by the time the Fourteenth Amendment was adopted, both science and law had rejected the ancient view.

A physician, who helped draft Virginia's 1848 state abortion statute, explained that science had rejected the ancient view that life began at quickening:

"(T)hat the embryo is endowed with an inherent vitality from the first moment of conception, and is therefore as

much entitled to the protection of the law before the period of "quickening" as after it, every well-informed physician must yield a ready assent. The old doctrine, once held by medical men...that the foetus first becomes animated, or endowed with distinct vitality, at the moment when the sensation of quickening is experienced by the mother, has been long since banished from the domain of science ... and now only finds a retreat in the dark and ancient caverns of common law...."

"(T)he civil rights of the unborn child are perfect from the very commencement of its being."

L.S. Joynes, M.D, "Foetus in Utero," *Virginia Medical Journal* 179-180, 187 (1856).

In 1860 the President of the American Medical Association condemned that ancient view as a "barbarous physiology" and urged the States to enact statutes to protect all stages of unborn life:

"This relic of a barbarous physiology needs to be exploded, and the truth should be generally promulgated, that, from the moment of conception, a new being is engendered." 13 *Transactions of the American Medical Association* 56-7 (1860)

And America's eminent professor of obstetric medicine wrote in 1860:

From the moment of fecundation, the new being becomes independent...its individuality is complete....(T)here is a progressive...advancing from one degree of perfection to another. Every protection, therefore, which is extended by human legislation to the young infant...should be equally effectual in securing the life of the embryo from

the earliest period of its existence.[55]

But the Court adopted a view of unborn life which 19th century medical science had rejected as "a barbarous physiology," which courts had ruled "never ought to have been the law anywhere,"[56] and which legislatures had condemned as criminal.

In construing the phrase in its constitution, "Everybody has the right to life," the Supreme Court of West Germany ruled that the word "everybody" did include the unborn, and the State had a duty to protect unborn life: "No distinction can be made among the several stages of developing life before birth, or between prenatal and postnatal life."

The medical and legal history show the framers and adopters of the Fourteenth Amendment made this same conclusion when they guaranteed life to "any person" without any exceptions for the unborn. They decided that unborn life was a progressive advancing from one degree of perfection to another, and there was no time when the unborn were not alive and the law could withdraw its protection of life.

Chief Justice Marshall ruled that the intention of the framers is the law, and for the Court to disobey it would be "treason to the Constitution." So the Constitution's guarantee of life to "any person" does include the unborn.

The Court claims that it can fabricate evidence to exclude anyone from the U.S. Constitution's guarantee of life to "any person." In effect, the Court claims FALSEHOOD IS TRUTH.

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[55] H.L. Hodge, M.D., *The Principles and Practice of Obstetrics* 78 (1864). Hodge's "name had become a household word throughout the land" and his book "valued among the very first works on obstetrics ever issued from the American or foreign press." R. Penrose, M.D., *Discourse on Life of H.L. Hodge* 20-21 (1872).

[56] *Mills* v. *Comm.*, 13 Pa. at 632 (1850).

E.

Due Process of Law Has Compelled the U.S. Supreme Court to Confess in Court that it Is Guilty of Mass Murder and Extermination.

For the **131st time**, the U.S. Supreme Court is accused of defying the Constitution's guarantee of life to "any person" and deliberately exterminating millions of victims whom the Constitution endeavors to preserve.

For the **107th time,** the U.S. Supreme Court is accused of mass murder in violation of state and federal criminal statutes.

For the **111th time**, the U.S. Supreme Court is accused of using criminal procedures to effect and maintain its *Roe v Wade* killings.

But, for three decades, the Court has never attempted to refute the charges.

Failure to deny a charge is admissible as a confession that the charge is true.[57]

At his trial for treason in 399 B.C., Socrates cross-examined one of his accusers: "(Y)ou are silent, and have nothing to say. But is not this rather disgraceful, and a very considerable proof of what I was saying?"

And this Court recognizes this ancient rule:

> "(T)he Court has consistently recognized that...silence in the face of accusation is a relevant fact.... Silence is often evidence of the most persuasive character." *Baxter* v. *Palmigiano*, 425 U.S. at 319 (1976).

Under the Court's own rulings, its silence is an admission

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[57] 4 Wigmore, *Evidence*, Sec. 1071-1073 (Chadborn rev. 1972). "Underlying the rule is the assumption that human nature prompts an innocent man to deny false accusations and consequently a failure to deny a particular accusation tends to prove belief in the truth of the accusation." *McCormick on Evidence*, Sec. 161 (1972).

that the charges are true:

> "Failure to contest an assertion, however, is considered evidence of acquiescence only if it would have been natural under the circumstances to object to the assertion in question." *United States v. Hale*, 422 U.S. 171, 176 (1975).

The circumstances leave no doubt that the court's silence is a confession that the charges are true.

First, the evidence proves the charges to be true. The Court decreed killings to be "liberty" which States had defined to be "murder." This is mere historical fact. No denial is possible. As Chief Justice John Marshall wrote, "a fact which has existed cannot be made never to have existed."[58]

Second, the charges were made in court, the place designated by law to hear such accusations. The Judges had a legal duty to refute the charges, if they could. Chief Justice John Marshall ruled that judges who "close their eyes on the Constitution" and "condemn to death those victims whom the Constitution endeavors to preserve" commit "crime."[59] The Court had a legal duty to fully hear allegations that Roe v. Wade was wrongly decided, and to obey the evidence.

Third, the Court's steadfast silence for three decades in the face of scores of accusations is unparalleled in the legal history of the world. The Court itself cited this circumstance as making confession by silence more trustworthy:

> "Silence gains more probative weight where it persists in the face of accusation, since it is assumed in such circumstances that the accused would be more likely than not to dispute an untrue accusation." *United States* v.

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[58] *Marbury* v. *Madison*, 1 Cranch 137, 167 (1803).

[59] *Marbury* v. *Madison*, 1 Cranch 137, 179-180 (1803).

Hale, 422 U.S. 171, 176 (1975).

Fourth, the evidence showed the United States was being ruled by a giant conspiracy to exterminate and mass murder, to overthrow the U.S. Constitution, and to impose Nazi doctrines on America. Never in history had it ever been more imperative to deny charges if they were untrue.

And **fifth**, the Justices met the charges in court by claiming that they must be obeyed even if they decreed the mass murder of Jews, or anyone else, to be liberty.

A government of laws can permit only one conclusion to be drawn from these facts: the U.S. Supreme Court confessed that the charges are true.

III.

IF *ROE* v. *WADE* IS A MISTAKE OF LAW, THEN ALL PUBLIC OFFICIALS, OR CITIZENS, WHO SUPPORT IT MAY BE GUILTY OF COMPLICITY IN EXTERMINATION, INCLUDING MASS MURDER.

We now arrive at the most important legal question in world history: Can the U.S. Supreme Court lawfully decree national extermination and mass murder to be liberty? The U.S. Supreme Court claims that it can.

But if *Roe* v. *Wade* is a mistake of law, then all the government officials, news media persons or citizens who helped to support and maintain it may be guilty of complicity in national extermination, including mass murder.

The general rule is that mistake of law is no excuse for breaking the law.[60] The Constitution's *ex post facto* provisions do not apply to judicial decisions which are a mistake of law.[61] The limited affirmative defense of reasonable reliance on an

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[60] R. Perkins, *Criminal Law* 920 (2d ed. 1969); Oliver Wendell Holmes, *The Common Law* 41 (Howe ed. 1963).

[61] *Ross* v. *Oregon*, 227 U.S. 150, 161 (1912).

official judicial opinion, thereafter determined to be a mistake of law, does not apply in homicide cases, much less national extermination and mass murder.[62] But even if it did, no reliance on *Roe v. Wade* could be reasonable in view of the above facts. So the law applied at Nuremberg applies here. Obedience to the decrees of the supreme judge is no defense to national extermination and mass murder.

Even if the U.S. Supreme Court held a gun to a man's head, and threatened death unless he obeyed *Roe v. Wade*, it would not be a defense to homicide. Blackstone stated the law: "(H)e ought rather to die himself than escape by the murder of an innocent."

In explaining why the Western democracies bowed to violence and the Nazis got away with monstrous crimes, Winston Churchill merely quoted Machiavelli: "Men avenge slight injuries, but not grave ones." Thus America is now ruled by a giant conspiracy to mass murder.

"Political language," wrote George Orwell, "is designed to make lies sound truthful and murder respectable." In his novel *1984*, Orwell described a tyranny which claimed, "Whatever the Party holds to be truth is truth," and defrauded its subjects into obedience with its slogans "FREEDOM IS SLAVERY" and "WAR IS PEACE."

This science fiction may appear implausible, yet for three decades the United States has been ruled by a Court which claims, "Whatever the Court holds to be truth is truth," and maintains obedience with its slogans- MASS MURDER IS LIBERTY, FALSEHOOD IS TRUTH, and TREASON IS LAW.

But all that will be swept away. The primitive idea, that

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[62] *Model Penal Code*, Section 2.04, Ignorance or Mistake (Proposed Official Draft 1962) and comments in the *Model Penal Code*, Tentative Draft No. 4, Comments on Sec. 2.04, page 138. R. Perkins, *Criminal Law* 928 (2d ed. 1969). A. Ernest, *Mass Murder is Liberty* 74-104 (1998)

some can gain by killing others, has no future. The message of our Declaration of Independence becomes more true every day - reverence for life is the only path to the future. Wherever we are, wherever in the universe our kind may go, our essential thought, the thought necessary for us to exist, will always be reverence for life.

CONCLUSION

Merely overruling *Roe* v. *Wade* will not remedy the wrong. The Court misguided this nation and the entire world. Now the Court must speak the obvious truth. The U.S. Constitution's guarantee of life to "any person" does include the unborn. State and federal governments have a duty to protect unborn life.

Alan Ernest,
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In The
Supreme Court of the United States

ALBERTO R. GONZALES, ATTORNEY GENERAL,

Petitioner,

v.

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., ET AL.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF OF MATERCARE INTERNATIONAL, JACK A. ANDONIE, M.D., and RAYMOND F. GASSER, PH.D., AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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INTEREST OF *AMICI CURIAE*[1]

Matercare International is a non-profit international organization of Catholic maternal health professionals (obstetricians, neonatologists, general practitioners, midwives and others) whose mission is to address and provide practical solutions to the poor state of maternal health throughout the world as indicated by the unacceptably high maternal mortality, morbidity and abortion rates. Healthcare professionals in the United States are an important part of Matercare International. In addition to collaborating with other health organizations to provide maternal health care in Ghana, Kenya and Rwanda, Matercare International members engage in research of the highest scientific and ethical standards to assist in the care of mothers both pre-natal and post-natal.

Jack A. Andonie, M.D., served as a medical expert in the federal court challenge to the Louisiana Partial Birth Abortion Ban Act of 1997, at a time when he was Clinical Professor in the Department of Obstetrics and Gynecology at Louisiana State University Medical School. During the course of his over thirty-six years in obstetrics and gynecology, Andonie examined and/or treated approximately twenty thousand women and delivered approximately ten thousand babies. He is a medical expert in the areas of pregnancy, the process of birth and birth. Andonie, who received his bachelor's degree from Loyola

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[1] Pursuant to Sup. Ct. R. 37.6, *amici* state that none of the counsel for the parties authored this brief in whole or in part. Monetary funding for the preparation of this brief has been requested in part from the Alliance Defense Fund. Pursuant to Sup. Ct. R. 37.3(a), the parties have consented to the filing of this brief. Letters of consent are being filed with the Clerk. Counsel for *amici* extend special thanks to Blackstone legal interns Sara F. Tappen and Joseph E. Giles.

University in New Orleans and earned his medical degree from LSU Medical School in 1962, is a diplomate of the American Board of Obstetrics and Gynecology and a fellow of the American College of Obstetrics and Gynecology. At the time of his affidavit included in this brief, Andonie was serving as Medical Director at Lakeside Hospital as well as teaching and practicing obstetrics-gynecology.

Raymond F. Gasser, Ph.D., is professor of cell biology and anatomy, and an adjunct professor of obstetrics and gynecology at Louisiana State University Health Sciences Center. Since 1980, Dr. Gasser has served as course director for human prenatal development, and has received 13 teaching awards. A prolific author, he wrote one of the classic embryology texts entitled *Atlas of Human Embryos*. He has produced a variety of audio-visual anatomy teaching tools. He is the principal investigator of the *Virtual Human Embryo*, which provides electronic images of whole and sectioned human embryos. The *Virtual Human Embryo* is a major joint research and education project of the Louisiana State University Health Sciences Center and the Human Developmental Anatomy Center in Washington, D.C., which is funded by the National Institutes of Health (NIH). Dr. Gasser is also a member of the Federative International Committee on Anatomical Terminology, serving on the Subcommittee on Human Embryological Terms.

In the interest of preventing the erosion of the legal and medical line between abortion and infanticide, *amici curiae* seek to inform this Court of the medical understanding of the definitions of pregnancy, the process of birth and birth in order to inform this Court's analysis of the legal implications that distinguish in utero abortion

procedures and the act of destroying a living child who is in the inevitable process of birth.

SUMMARY OF THE ARGUMENT

This Court's decision in *Stenberg v. Carhart*, 530 U.S. 914 (2000) does not control this case because *Stenberg* did not directly address a ban on the killing of a child in the birth process who is partly "outside the body of the mother." *See* 18 U.S.C. § 1531(b)(1)(A).

The abortion liberty has always been defined by this Court as a woman's right to "terminate her pregnancy." *See, e.g., Planned Parenthood v. Casey,* 505 U.S. 833, 844 (1992). Medical science establishes that the onset of the birth process terminates pregnancy. Therefore, any ban on killing after the onset of the process of birth and when the child is partly outside the body of the mother does not interfere with the right to terminate pregnancy. Consequently, this Court's abortion jurisprudence, including analytical concepts such as undue burden, health exceptions and viability do not govern the question of whether the Congressional ban is constitutional. As Justice Marshall commented during the second oral argument in *Roe v. Wade*, 410 U.S. 113 (1973), killing a child in the process of birth "is not an abortion."[2]

Because abortion is not prevented by the Congressional ban on killing a child in the birth process who is partly outside the mother's body, Congress's ban is constitutional if it is rationally related to a legitimate government

[2] *See* Transcript of Reargument of *Roe v. Wade, infra* Section I(A).

interest. *See Washington v. Glucksberg,* 521 U.S. 702 (1997). Congress's ban on killing a child who is in the process of birth and partly outside the mother's body is reasonably related to its interest in preventing the erosion of the line between abortion and infanticide.

On a separate matter, the district court below applied an apparent double standard when assessing the credibility of the Government's medical expert witnesses. Specifically, the district court expressly highlighted and negatively commented on the pro-life beliefs, practices and associations of the Government's medical experts, while making no mention of the self-interested pro-abortion rights views and associations of respondents' experts. *Planned Parenthood Federation of America v. Ashcroft*, 320 F. Supp. 2d 957, 998 (N.D.Cal. 2004).

ARGUMENT

I. AS JUSTICE MARSHALL COMMENTED DURING THE REARGUMENT OF *ROE*, KILLING A CHILD IN THE PROCESS OF BEING BORN "IS NOT AN ABORTION"

A. Abortion Related Legal Concepts like "Undue Burden" and "Health Exception" Do Not Apply to Congress's Ban on Killing a Child During the Process of Birth.

Since 1973, this Court has consistently defined the abortion liberty as the right of a woman to choose "whether or not to **terminate her pregnancy**." *Roe v. Wade,* 410 U.S. 113, 153 (1973) (emphasis added). As set forth below, medical science establishes that the onset of the birth process terminates pregnancy. Therefore, Congress's

ban of killing a child in the birth process who is partly outside the mother's body addresses conduct that intentionally occurs *after* termination of the pregnancy. Consequently, the Partial Birth Abortion Ban Act of 2003 ("the Act")[3] does not interfere with the right to terminate pregnancy. This Court's decision in *Stenberg v. Carhart*, 530 U.S. 914 (2000) does not control this case because *Stenberg* did not directly address a ban on the killing of a child in the birth process who is partly "outside the body of the mother." *See* 18 U.S.C. § 1531(b)(1)(A). Consequently, this Court's abortion jurisprudence, including the undue burden standard and the ostensible requirement of a "health" exception, does not govern the question of whether the Act is a constitutional exercise of legislative authority.

During the 1972 reargument of *Roe*, this Court discussed whether the term "abortion" encompassed killing a child during the process of birth. The following exchange between Justice Marshall and counsel for the State of Texas occurred in the context of a discussion about the Texas parturition statute, which had not been challenged as unconstitutional:

. . . .

JUSTICE MARSHALL: What does that [parturition] statute mean?

MR. FLOWERS: Sir?

JUSTICE MARSHALL: What does it mean?

MR. FLOWERS: I would think that –

---

[3] Partial Birth Abortion Ban Act of 2003, 18 U.S.C. § 1531 (2003) ("the Act").

> **JUSTICE STEWART:** That it is an offense to kill a child in the process of childbirth?
>
> **MR. FLOWERS:** Yes sir. It would be immediately before childbirth, or right in the proximity of the child being born.
>
> **JUSTICE MARSHALL:** *Which is not an abortion.*
>
> **MR. FLOWERS:** Which is not – would not be an abortion, yes, sir. You're correct, sir. It would be homicide.

Reargument of Roe v. Wade, October 11, 1972 (emphasis added).[4]

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[4] This exchange between Justice Marshall and Mr. Flowers, counsel for the State of Texas, occurred during the 1972 reargument of *Roe* in the context of a discussion about the Texas parturition statute, which had not been challenged as unconstitutional. The entire written transcript of the October 11, 1972 reargument can be found at http://www.oyez.org/oyez/resource/case/334/reargument/transcript (last checked July 31, 2006).

This exchange followed Flowers's comment that the plaintiffs had attacked Texas's abortion statutes, found at Articles 1191 through 1196, with the exception of Article 1195. Flowers then quoted the entirety of the **unchallenged** Article 1195, which provided: "Whoever shall during parturition of the mother **destroy the vitality or life in a child in a state of being born and before actual birth, which child would otherwise have been born alive,** shall be confined in the penitentiary for life or for not less than five years." (emphasis added). This provision is currently codified at Tex. Rev. Civ. Stat. Ann. art. 4512.5.

This Court's decision in *Roe* acknowledged in footnote 1 that Texas' parturition statute was "**not attacked.**" 410 U.S. at 117 n.1. In 1974, a Texas Attorney General opinion echoed Justice Marshall, concluding that Article 1195 is "unaffected" by *Roe* because the element requiring that the child "**be in a state of being born**" means that the article "**is not, in truth, an abortion statute.**" *Tex. Op. Atty. Gen.*, Opinion No. H-369 at 3 (August 13, 1974) (emphasis added).

B. The Right to "Terminate Pregnancy" Does Not Include the Right to Kill a Child During the Process of Birth; There is no Such Thing as a Vaginal Abortion.

Justice Marshall's comment that killing a child in the process of birth "is not an abortion" is fully supported by established medical science. It is also confirmed by this Court's consistent definition of the abortion liberty as the right to terminate pregnancy.

1. Medical science establishes that pregnancy is terminated by the onset of the birth process.

In *Roe*, this Court's understanding of abortion was informed by medical science: "[the pregnant woman] carries an embryo and, later, a fetus, if one accepts the medical definitions of the developing young, in the human **uterus**." 410 U.S. at 159 (emphasis added) (*citing* DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 478-479, 547 (24th ed. 1965)). Congress, like this Court in *Roe* and its progeny, also relied upon medical definitions when it enacted the Partial Birth Abortion Ban Act of 2003. Because medical science establishes that pregnancy is terminated by the onset of the birth process, **the Act does not regulate "abortion," as that term is understood both medically and legally**.

The development of a human being takes place in two stages. The first stage is pregnancy, which begins at conception and ends when the living child is delivered or removed from the uterus into the birth canal. *See* TABER'S CYCLOPEDIC MEDICAL DICTIONARY 1543, 2046 (18th ed. 1997) (defining *pregnancy* as the "condition of carrying an

embryo [or fetus] in the uterus;" defining *uterus* as "[a] reproductive organ for containing and nourishing the embryo and fetus . . . to the time the fetus is born"). As such, the pregnancy stage is confined to the development of the child while in the uterus of his or her mother.

The stage after pregnancy is birth, followed by the whole process of postnatal growth through adulthood and old age. The birth stage starts when the living child begins to exit the womb into the birth canal.[5] *See* TABER'S at 223 (defining *birth* as the "passage of a child from the uterus"); *see also* DORLAND'S at 202 (28th ed. 1994) (defining *birth* as "the act or process of being born" and distinguishing *complete birth* as "the complete separation of the infant from the maternal body (after cutting the umbilical cord)").[6]

Vaginal birth is an irreversible process, not a single event. As a matter of medical fact, pregnancy is terminated and the process of birth has begun once the membranes of the amniotic sac are ruptured and the living fetus emerges from the uterus, beyond the cervical os and into the vaginal (birth) canal. *See Declaration of Jack A. Andonie, M.D.*, ¶¶ 8-10 (Appendix B); *Declaration of Raymond Gasser, Ph.D.*, ¶¶ 10-11 (Appendix C). Thus, there is a significant medical distinction between the locus

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[5] The terms womb and uterus are interchangeable. *See* DORLAND'S at 1846 (womb is defined as "the uterus").

[6] In *Roe*, this Court did not "resolve the difficult question of when **life** begins," because "the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer." 410 U.S. at 159 (emphasis added). Here, by contrast, there is no need to speculate about when **birth** begins. There is no raging debate or lack of consensus about the process of birth among "those trained in the respective disciplines of medicine, philosophy, and theology." *Id.*

where intrauterine fetal stasis is maintained (*i.e.*, pregnancy), and the dynamic process of birth. Pregnancy has never occurred or been maintained in the vaginal canal.[7] The delivery of the child into the birth canal means that pregnancy has been terminated thus making the complete **birth** of the child **inevitable**.[8]

Indeed, in the medical vernacular, the onset of the birth process is one method of terminating a pregnancy, while induced abortion is another.[9] Medically, then, it is an oxymoron to speak in terms of "aborting" a living fetus that is partially vaginally delivered. This is so because induced abortion is any procedure that causes fetal death **in utero**, thereby causing "the premature expulsion from the uterus of the products of conception."[10] In other words, there is no such thing as a "vaginal abortion." That non-medical term, sometimes used by abortion providers to describe what they refer to as "intact D&X," is simply a euphemism for the criminal termination of the life of a child after the pregnancy has already been terminated by the onset of the process of birth.

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[7] App. 8, *Andonie Decl.* at ¶ 10; App. 16, *Gasser Decl.* at ¶ 11.

[8] The Declarations of Dr. Andonie and Dr. Gasser are part of the official record in the Louisiana partial birth abortion case that was pending in the United States Court of Appeals for the Fifth Circuit at the time this Court ruled in the 2000 case of *Stenberg v. Carhart*. *Causeway Medical Suite v. Foster*, 43 F. Supp. 2d 604 (E.D. La. 1999), *aff'd*, 221 F.3d 811 (5th Cir. 2000). These basic and unquestionable medical facts testified to by Louisiana's medical experts were not controverted.

[9] App. 8, *Andonie Decl.* at ¶ 6.

[10] DORLAND'S at 4; App. 8, *Andonie Decl.* at ¶¶ 6-7. Actually the phrase "fetal death in utero" is a tautology because "fetal death" means "death in utero." DORLAND'S at 430.

Therefore, in enacting the Partial Birth Abortion Act of 2003, Congress was not regulating abortion at all, as that term is medically and legally understood. Rather, Congress proscribed the killing of a child after the process of birth has begun and when the child is partly outside the woman's body, and labeled that crime "*partial birth* abortion."[11]

That the Act is not in fact regulating abortion is a conclusion supported by medical science. The intentional delivery of a living child from the uterus into the vaginal canal and partly outside the women's body signals a momentous medical, and now legal, event. Thus, where the Act speaks in terms of "deliberately and intentionally vaginally delivers a living fetus,"[12] it has thereby given effect to the medical distinction between pregnancy and birth. By its terms, then, the Act regulates the process of birth, also referred to as parturition. The terms of Congress's ban are clearer and more explicit than those of the Nebraska statute considered by this Court in *Stenberg v. Carhart*, in that the federal Act does not regulate the in utero procedure of dismembering the unborn child known as the "classic D&E" abortion method.[13] The Act narrowly bans killing the child in the unstoppable process of birth.

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[11] Although "partial birth abortion" is a not a medical term used by abortion providers, it has become a legal term of art that was adopted by Congress to describe the crime of killing a child in the process of being born.

[12] Act at § 3(b)(1)(A), 117 Stat. 1206 (2003).

[13] In 1992, the pioneer of the partial birth abortion procedure, Dr. Martin Haskell, distinguished his so-called "intact D&X" procedure from the "established D&E" method: "Classic D&E is accomplished by dismembering the fetus ***inside the uterus*** with instruments and removing the pieces through an adequately dilated cervix." Martin

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2. Abortion jurisprudence recognizes only a woman's right to terminate her pregnancy; this Court has never held that there is a right to kill a child in the process of being born.

This Court has consistently formulated the abortion liberty as a woman's right to "terminate her pregnancy." For example, in *Roe*, this Court stated,

> This right of privacy . . . is broad enough to encompass a woman's decision whether or not to **terminate her pregnancy**.

Roe, 410 U.S. at 153 (emphasis added).

Similarly, in *Casey*, this Court stated:

> From what we have said so far it follows that it is a constitutional liberty of the woman to have some freedom to **terminate her pregnancy**.[14]

Casey, 505 U.S. at 869 (emphasis added).

Haskell, M.D., *Dilation and Extraction for Late Second Trimester Abortion* 28 (NAF, Sept. 13, 1992) (emphasis added).

[14] In *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), this Court repeatedly articulated the abortion liberty as a "woman's right to **terminate her pregnancy**":

> "Yet 19 years after our holding that the Constitution protects **a woman's right to terminate her pregnancy** in its early stages . . . , that definition of liberty is still questioned." *Id.* at 844. "Constitutional protection of **the woman's decision to terminate her pregnancy** derives from the Due Process Clause of the Fourteenth Amendment." *Id.* at 846. "The extent to which the legislatures of the States might act to outweigh the interests of the woman in choosing **to terminate her pregnancy** was a subject of

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Once the child has moved from the pregnancy stage to the birth process, a woman's right to "terminate her

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debate both in *Roe* itself and in decisions following it." *Id.* at 853. "We conclude that the basic decision in *Roe* was based on a constitutional analysis which we cannot now repudiate. The woman's liberty is not so unlimited, however, that from the outset the State cannot show its concern for the life of the unborn, and at a later point in fetal development the State's interest in life has sufficient force so **that the right of the woman to terminate the pregnancy** can be restricted." *Id.* at 869. "We conclude the line should be drawn at viability, so that before that **time the woman has a right to choose to terminate her pregnancy**." *Id.* at 870. "The woman's right to terminate her pregnancy before viability is the most central principle of *Roe v. Wade*." *Id.* at 871. "Though **the woman has a right to choose to terminate or continue her pregnancy** before viability, it does not at all follow that the State is prohibited from taking steps to ensure that this choice is thoughtful and informed." *Id.* at 872. "'Roe did not declare an unqualified constitutional right to an abortion, as the District Court seemed to think. Rather, the right protects the woman from unduly burdensome interference with **her freedom to decide whether to terminate her pregnancy**.'" *Id.* at 874 (quoting *Maher v. Roe*, 432 U.S. 464, 473-474 (1977) (internal quotation marks omitted)). "All abortion regulations interfere to some degree with a **woman's ability to decide whether to terminate her pregnancy**." *Id.* at 875. "Not all burdens on the right to decide whether **to terminate a pregnancy** will be undue." *Id.* at 876. "Our adoption of the undue burden analysis does not disturb the central holding of *Roe v. Wade*, and we reaffirm that holding. Regardless of whether exceptions are made for particular circumstances, a State may not prohibit any woman from making the ultimate decision **to terminate her pregnancy** before viability." *Id.* at 879. "Whether the mandatory 24-hour waiting period is nonetheless invalid because in practice it is a substantial obstacle to a **woman's choice to terminate her pregnancy** is a closer question." *Id.* at 885. "Rather, the right protected by *Roe* is a **right to decide to terminate a pregnancy** free of undue interference by the State." *Id.* at 887 (emphasis added to all quotations).

pregnancy" is not implicated because there is no longer a pregnancy to terminate. After the commencement of the birth process, the intentional ending of the life of a partially born child is not an abortion at all, but rather the unlawful killing of a human being.

In *Wynn v. Scott*, federal District Judge Marshall addressed a hypothetical statute providing that if a physician had a choice of procedures to terminate the pregnancy, both of equal risk to the woman, the state could require the physician to choose the procedure which is least likely to kill the fetus. The court concluded that "[t]his choice would not interfere with the woman's right to terminate the pregnancy. **It never could be argued that she had a constitutionally protected right to kill the fetus. She does not.**" 449 F. Supp. 1302, 1321 (N.D. Ill. 1978) (emphasis added), *appeal dismissed*, 439 U.S. 8 (1978), *aff'd sub nom., Wynn v. Carey*, 599 F.2d 193 (7th Cir. 1979) (citing Note, *Medical Responsibility of Fetal Survivor Under Roe and Doe*, 10 Harv. Civ. Lib.-Civ. Rt. Rev. 444 (1975)).

Although a woman may have a qualified right to an empty womb, this Court has never held that she has a right to a dead child. *Cf. Planned Parenthood v. Ashcroft*, 462 U.S. 476, 483 n.7 (1983) (plurality) (describing as "remarkable" testimony of abortion provider Dr. Robert Crist that "'the abortion patient has a right not only to be rid of the growth, called the fetus in her body, but also a right to a dead fetus'").

Yet, at least one of respondents' experts fails to understand this as revealed by the following disturbing testimony by abortion provider Dr. Creinin in the California district court:

Q. Doctor, if a woman's cervix was so dilated the fetus could be delivered in [sic] intact it would not be necessary to collapse the skull because the fetus could pass through the cervix, right?

A. Correct.

Q. But you would not allow the fetus to pass intact if the fetus were at or about 24 weeks in gestation, correct?

A. Correct.

Q. Because if the fetus were close to 24 weeks, and you were performing a transvaginal surgical abortion **you would be concerned about delivering the fetus entirely intact because that might result in a live baby that may survive, correct**?

A. **You said I was performing an abortion, so since the objective of the abortion is to not have a live fetus, then that would be correct.**

Q. In your opinion, if you were performing a surgical abortion at 23 or 24 weeks and the cervix was so dilated that the head could pass without compression, you would **do whatever you needed to do in order to make sure that the live baby was not delivered, wouldn't you**?

A. **Whatever, I needed, meaning whatever surgical procedures I needed to do as part of the procedure? Yes. Then, the answer would be: Yes.**

Q. And one step you would take to avoid delivery of a live baby would to be to deliver or hold

the fetus' head on the internal side of the cervical os in order to collapse the skull: is that right?

A. Yes, because the objective of my procedure is to perform an abortion.

Q. And that would ensure that you did not deliver a live baby?

A. Yes.

Tr. Vol. 5 at 747:18-748:23 (Creinin).

It is obvious from this testimony that this Court's jurisprudence concerning a woman's right to "terminate her pregnancy" has been distorted into the erroneous belief that abortion practitioners have a right to take the lives of children even *after* pregnancy has been terminated by the onset of the birth process and when part of the child is outside the mother's body. Therefore, Congress acted reasonably to reinforce the line between abortion and infanticide. *See* Section II, *infra*.

3. The abortion-related concepts of "viability" and "health exception" are irrelevant.

Amici recognize the principle outlined in *Casey* that "[b]efore viability, the State's interests are not strong enough to support a prohibition of abortion." *Casey*, 505 U.S. at 846. However, because medical science establishes that pregnancy is terminated by the onset of the birth process, the Act does not regulate "abortion," as that term is understood both medically and legally.

"Viability" is about gestation; "partial birth abortion" is about location. Viability is a variable in the equation

this Court developed to determine the strength of the state's interest in protecting an unborn child, as weighed against the right of the woman to choose to terminate her pregnancy. The issue of whether Congress may protect the life of an unborn child necessarily arises prior to the time that the pregnancy has been terminated, *i.e.*, while the fetus is gestating in the womb. Thus, the pregnancy stage provides the only occasion where the decision of whether or not to permit the killing of a human being is dependent upon his or her viability.

When the child has been delivered from the uterus into the vaginal canal, the woman is no longer "pregnant." Thus, abortion jurisprudence regarding viability does not provide the proper analytical framework to assess an asserted right to kill a child after the pregnancy has been terminated by the onset of the birth process. Congress's authority to ban killing during the birth process should not, therefore, depend on whether the partially born child's gestational age is nine months or five months; whether the birth has begun naturally or has been artificially induced; or whether the child is "viable" or "nonviable." The only relevant inquiry after the child is in the birth canal is whether the child is "living," and is outside of the mother's body. Act at § 3(b)(1)(A).

Likewise, this Court has stated that, in the context of abortion, the issue of maternal "health" can override a governmental interest. *See, e.g., Doe v. Bolton*, 410 U.S. 179, 192 (1973). Here, where Congress is regulating the process of birth to prevent the slide to infanticide, the issue of maternal health, absent risk to the mother's life, also does not override the state's interest.

To expand the concept of viability and so-called health exceptions to the process of birth would transform the right to terminate pregnancy into a new constitutional right to kill a child even after the pregnancy is terminated. As recognized by Judge Straub's dissent in the Second Circuit partial birth abortion challenge to the Act, application of abortion principles to statutes regulating birth would thus erode the barrier between abortion and infanticide.[15]

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[15] Second Circuit Judge Chester Straub said the following in his dissent in *Nat'l Abortion Fed'n v. Gonzales*, 437 F.3d 278, 296-314 (2d Cir. 2006):

> I find the current expansion of the right to terminate a pregnancy to cover a child in the process of being born morally, ethically, and legally unacceptable. *Id.* at 312.
>
> * * *
>
> Although I acknowledge that no court has held that there is a special constitutional standard of protection for the fetus in the process of being born, a woman's right to terminate a pregnancy has never extended to the destruction of a child during parturition. *Id.* at 312 (*citing Roe*, 410 U.S. at 117 n.1).
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> * * *
>
> If the intent of the mother controls the scope of her right to destroy her offspring, there is no reason why she should not be able to destroy the child after it has completely been separated from her body.
>
> I disagree with Chief Justice Walker that the fact that the Act is not limited to post-viability abortions necessarily vitiates the compelling interest of the State in preventing the procedure to distinguish abortion from infanticide. Once a fetus is born, its viability ceases to be relevant to determining the constitutional protections to which it is entitled. *Id.* at 311 n.14.

II. THE ACT ADVANCES CONGRESS'S LEGITIMATE INTEREST IN PREVENTING THE EROSION OF THE LINE BETWEEN ABORTION AND INFANTICIDE.

The Act regulates the process of birth, not abortion. Consequently, the subjective medical judgment of the abortion provider must give way to Congress's regulation as long as it has a rational basis. The Act is rationally related to Congress's legitimate interest in preventing the erosion of the line between abortion and infanticide.[16] The Court's recent decision in *Washington v. Glucksberg*, 521 U.S. 702 (1997), is instructive on this point.

In *Glucksberg*, this Court held that government has the right to proscribe, not merely regulate, physician-assisted suicide notwithstanding a physician's best medical judgment that assisted suicide is the best and most appropriate way to relieve the patient's pain or terminal illness. *Id.* at 734. The State of Washington argued that "permitting assisted suicide will start it down the path to voluntary and perhaps involuntary euthanasia." *Id.* at 732. This Court agreed: "Washington's ban on assisted suicide prevents such erosion." *Id.* at 733. Because no fundamental right was implicated, a rational basis analysis was applied to reach the conclusion that "Washington's ban on assisted suicide is at least reasonably related to [its] promotion and protection" against abuses that could lead to the involuntary euthanasia of vulnerable neonates or elderly adults. *Id.* at 734.

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[16] The term **infanticide** is defined as

> The murder or killing of an infant soon after its birth. The fact of the birth distinguishes this act from 'feticide' or 'procuring abortion,' which terms denote the destruction of the fetus **inside the womb**.

BLACK'S LAW DICTIONARY 699 (5th ed. 1979) (emphasis added).

Like Washington's ban on assisted suicide, Congress's ban on killing a child in the process of birth who is partly outside the mother's body is reasonably related to its interest in preventing the erosion of the line between abortion and infanticide. Stated differently, the Act creates a firewall against infanticide.

Congress's concern with avoiding the slippery slope to infanticide is neither hypothetical nor irrational. It is not hypothetical because serious proposals for the legalization of infanticide have been championed by prominent academicians. For example, Professor Peter Singer, who holds an endowed chair at Princeton University, justifies infanticide based on his position that "[i]f the fetus does not have the same claim to life as a person, it appears that the newborn baby does not either, and the life of a newborn baby is of less value to it than the life of a pig, a dog, or a chimpanzee is to the nonhuman animal." Peter Singer, *Practical Ethics* 169 (2d ed., Cambridge Univ. Press 1997). The following passage illustrates Singer's reasoning:

> [T]he fact that a being is a human being, in the sense of a member of the species Homo sapiens, is not relevant to the wrongness of killing it; it is, rather, characteristics like rationality, autonomy, and self-consciousness that make a difference. Infants lack these characteristics. Killing them, therefore, cannot be equated with killing normal human beings, or any other self-conscious beings. This conclusion is not limited to infants who, because of irreversible intellectual disabilities, will never be rational, self-conscious beings . . . No infant – disabled or not – has as strong a claim to

> life as beings capable of seeing themselves as distinct entities, existing over time.[17]

Id. at 182.

Congress's concern is not irrational because the Act is reasonably related to preventing the slippery slope to infanticide. In the first round of partial birth litigation, Chief Judge Posner of the United States Court of Appeals for the Seventh Circuit criticized bans on partial birth abortion as being "irrational" because such bans would not prevent "killing the [same] fetus in utero." *Planned Parenthood v. Doyle*, 162 F.3d 463, 471 (7th Cir. 1998) (Posner, J); *see also Hope Clinic v. Ryan*, 195 F.3d 857, 878-879 (7th Cir. 1999) (*en banc*) (Posner, J., dissenting). Judge Posner's criticism misses the point. Congress's purpose was not to prevent the killing of a fetus in utero (abortion); rather, its purpose is to prohibit the killing of a child in the process of birth who is partly outside the mother's body so as to prevent the erosion of the line between abortion and infanticide.

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[17] Professor Singer contends that "the life of a fetus . . . is of no greater value than the life of a nonhuman animal at a similar level of rationality." Singer then "admit[s] that these arguments apply to the newborn baby as much as to the fetus. A week-old baby is not a rational and self-conscious being, and there are many nonhuman animals whose rationality, self-consciousness, awareness, capacity to feel, and so on, exceed that of a human baby a week or a month old." Singer then states that the "widely accepted views about the sanctity of infant life . . . need to be challenged." To support his position in favor of infanticide, Singer reasons that "we should put aside feelings based on the small, helpless, and – sometimes – cute appearance of human infants" whose "helplessness or innocence" should not be preferred to the equally helpless and innocent fetus, "or, for that matter, to laboratory rats who are 'innocent' in exactly the same sense." *Id.* at 169-170.

In *Glucksberg*, this Court recognized the "reasonableness of the widely expressed skepticism about the lack of a principled basis for confining the right [to assisted suicide]." *Glucksberg*, 521 U.S. at 733 n.23 (quoting *Brief for the United States as Amicus Curiae* 26 ("Once a legislature abandons a categorical prohibition against physician assisted suicide, there is no obvious stopping point")); *see also id.* at 785 (Souter, J., concurring) ("[t]he case for the slippery slope is fairly made out here, . . . because there is a plausible case that the right claimed would not be readily containable"). Just as Washington's ban on assisted suicide is reasonable because there is no principled basis for confining the "right," so Congress's ban on killing a child in the process of birth is reasonable because there would be no principled basis for confining that "right" either.

For example, if a doctor may kill a child whose body has been intentionally delivered into the birth canal except for the head, why may he not also kill a child who has been partially delivered head first? And if he may kill a child who has been partially delivered head first, why may he not kill the child whose entire body is outside of the mother except for one the child's feet which he holds in the birth canal? And if he may kill a child whose foot or little toe is held in the birth canal, why, then, may the doctor not kill the child who is completely expelled from her mother's body, but still attached to the umbilical cord?

III. THE DISTRICT COURT APPLIED AN APPARENT DOUBLE STANDARD WHEN ASSESSING THE CREDIBILITY OF THE GOVERNMENT'S MEDICAL EXPERTS.

Ordered liberty, the goal of the United States Constitution, and especially of Article III courts, rests on the bedrock principles of fundamental fairness and equal justice. Fairness and justice imply and require a single standard of judgment for all. Double standards undermine such traditional core notions of fair play and justice by undercutting the rule of law and engendering a cynical disregard for the integrity of the judiciary.

Unfortunately, the district court below applied an apparent double standard[18] when assessing the credibility

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[18] While this brief highlights an apparent double standard in the California district court's **credibility** determination, the following cases on the issue of **admissibility** are instructive of the underlying double standard that was expressly acknowledged by at least one Appellate Court Judge:

> In *Richmond Medical Center for Women v. Hicks*, 409 F.3d 619, 642-644 (4th Cir. 2005), the district court granted summary judgment after discrediting both of the government's experts' testimony by striking Dr. Giles' testimony as a whole and striking selected portions of Dr. Seeds' testimony. *Id.* at 509-512. Nowhere in the district court's opinion are Dr. Seeds' credentials listed. But Judge Niemeyer's dissent on appeal emphasizes the sufficiency of Dr. Seeds' credentials (expert in maternal/fetal medicine; "highly qualified"). *Id.* at 644. Judge Niemeyer's dissent explains that the district court's exclusion of Dr. Giles' and Dr. Seeds' testimony **"created a double standard and was an abuse of discretion."** . . . "The exclusion of Dr. Seeds' testimony is so highly irregular that it is difficult for me to conceive of the motive of the district court's ruling" . . . **"The District Court concluded solely from the fact that Dr. Seeds does not perform abortions that his testimony was unreliable."** *Id.* at 644 (emphasis added).

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of the Government's medical expert witnesses. Specifically, the district court expressly highlighted and negatively commented on the pro-life beliefs, practices and associations of the petitioner's experts, while making no mention of the self-interested pro-abortion rights views and associations of respondents' experts. *Planned Parenthood Federation of America v. Ashcroft*, 320 F. Supp. 2d 957, 998 (N.D.Cal. 2004).

Under the section of the district court's opinion entitled "Credibility of Witnesses," the court "found all of the plaintiffs' experts not only qualified to testify as experts, but **credible** witnesses based largely on their **vast experience in abortion practice**." *Id.* at 998 (emphasis added). Contrary to this blanket approval given to all of respondents' abortion provider experts, the district court's analysis of the credibility of the petitioner's experts began with the telling statement that all of the Government's experts "revealed a strong objection either to abortion in general or, at a minimum," to partial birth abortion. *Id.*

The district court then concluded that the petitioner's experts' "objections to entirely legal and **acceptable** abortion procedures color, to some extent, their opinions . . . ." *Id.* (emphasis added). This characterization of "acceptable" precisely reveals the prejudgment at the

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In *Evans v. Kelley*, 977 F. Supp. 1283, 1288, 1295 (E.D. Mich. 1997), Dr. Cook was singled out as holding pro-life associations/views. *Id.* at 1288. His testimony was afforded less credibility on the grounds that "given Dr. Cook's limited experience with abortion . . . his opinions are clearly outweighed by the otherwise uniform evidence to the contrary presented by the doctors who have great familiarity with both procedures." *See id.* at 1295 n.17 – and this despite the fact that the court describes him as an expert ObGyn concerning high-risk pregnancies, including termination of such pregnancies. *See id.* at 1288.

heart of the double standard applied by the district court. What constitutes an "entirely legal and acceptable abortion procedure" both begs the legal question at issue and injects an extra-judicial value judgment.

In light of this prejudgment or bias, the district court's analysis of the credibility of the petitioner's witnesses is suspect. For example, in the "Credibility of Witnesses" section of the district court opinion, the court made the following comments regarding the Government's medical experts:

> Dr. Sprang testified that he 'wouldn't be comfortable actually taking the life of the fetus.' In his 'practice, if patients want to have an abortion, they are referred to abortion providers.' 320 F. Supp. 2d at 998-99 (*quoting* Tr. Vol. 7 at 1060:6-7 (Sprang)).
>
> Dr. Shadigian is a member of AAPLOG, the American Association of Pro-Life Obstetricians and Gynecologists, and likewise, will not personally perform an abortion on a previable fetus that has not already died unless 'the woman is so sick that the only way she is going to survive is to have the pregnancy ended.' *Id.* at 999 (*citing* Tr. Vol. 8 at 1210:6-21 (Shadigian)).
>
> Dr. Bowes similarly testified that he would not personally perform an abortion even to save the life of one of his patients unless he believed that there was at least a 50% likelihood that she would die absent the abortion – even if the

> pregnancy was the result of rape or incest. *Id.* (*citing* Tr. Vol. 6 at 977:1-12 (Bowes)).[19]
>
> Additionally, Dr. Cook testified that because of his beliefs, he will not perform abortions for 'elective' reasons. *Id.* (*quoting* Tr. Vol. 9 at 1353:25-1354:2 (Cook)).

Absolutely no mention was made of the obviously self-serving beliefs and pro-abortion practices of the respondents' physicians who routinely perform many abortions. Nor did the district court discuss whether the abortion providers belong to any medical or abortion trade associations that support or advocate for unregulated legalized abortion.

In addition, the court overlooked the fact that the Government's maternal-fetal medicine and ObGyn experts, while not doing abortions per se, have experience doing technically comparable procedures (namely procedures on dead fetuses or labor inductions for live fetuses who must be delivered early). *See, e.g.*, Tr. Vol. 6 at 881:1-883:16 (Bowes); Tr. Vol. 7 at 1035:1-1036 (Sprang); Tr. Vol. 8 at 1193:22-1204:13 (Shadigian); Tr. Vol. 9 at 1347:4-1361:2 (Cook) (describing comparable procedures to D&E and intact D&X where the fetus is already dead and the

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[19] Tellingly, the district court described the testimony of one of the pro-life witnesses as "particularly credible" when referencing points on which the witness's statements could be read as being in disagreement with Congress's findings. Apparently, medical experts who do not perform abortions for reasons of conscience are most valued under this double standard when they serve the abortion side of the litigation.

procedure is used to complete or terminate the pregnancy).[20]

Singling out for negative treatment only the pro-life views and associations of petitioner's experts while giving

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[20] In *Planned Parenthood Cincinnati Region v. Taft*, 444 F.3d 502, 514-515 (6th Cir. 2006), the Appellate Court acknowledges that the limitations imposed by the district court on Dr. Crockett's expert testimony **were suspect**, that the district court ignored her testimony concerning a large portion of her experience, and that **"the only conceivable reason for failing to recognize Dr. Crockett as an expert on elective medical and surgical abortion was, in fact, because she does not perform elective abortions."** *Id.* at 515 (emphasis added). The majority opinion of the Sixth Circuit in *Taft* used an interesting example to illustrate the "abuse of discretion" in failing to admit the testimony of non-abortion performing medical experts:

> During the evidentiary hearing on the preliminary injunction, the district court recognized the State's witness, Dr. Crockett, as an expert in the areas of obstetrics, gynecology and the FDA approval process but refused to allow Dr. Crockett to testify as an expert regarding medical and surgical abortion or the critical review of medical literature. The State argues that refusing to recognize Dr. Crockett as an expert on medical and surgical abortion because she did not perform elective abortion procedures was an abuse of discretion. The State argues that performing elective abortion procedures is not a prerequisite to being an expert on such procedures and points out that such a rule would make it extremely difficult for governmental entities to secure the services of expert witnesses in such cases. The practical point is well taken, and the legal principle is sound. As with any other procedure or topic, an individual can acquire expertise regarding elective abortion procedures through a variety of means other than actually performing the precise procedure at issue. *See, e.g., Berry v. City of Detroit*, 25 F.3d 1342, 1350 (6th Cir. 1994) **(observing that an aeronautical engineer would be qualified to testify about the flight of a bumblebee based on general flight principles even if he had never actually seen a bumblebee)**.

Id.

a free pass to the respondents' experts is a clear and corrosive double standard. This double standard is all the more egregious because of this Court's recognition that opposition to abortion, even among physicians, is widespread, reasonable, respectable and in good faith.

This Court's abortion jurisprudence reflects the understanding that the practice of human abortion has "profound moral and spiritual implications," *Planned Parenthood v. Casey*, 505 U.S. 833, 850 (1992), and that "men and women of good conscience can disagree" about those implications and can find abortion "offensive to [their] most basic principles of morality." *Id.* Although legal, this Court has recognized that "reasonable people" will differ as to the morality of abortion, *id.* at 853, and "there are common and respectable reasons for opposing it." *Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263, 270 (1993). This Court also understands that millions of citizens "recoil at the thought of a law that would permit" abortion. *Stenberg*, 530 U.S. 914, 920 (2000).

Even as far back as *Roe v. Wade*, this Court expressed an "awareness of the sensitive and emotional nature of the abortion controversy, of the vigorous opposing views, **even among physicians**, and of the deep and seemingly absolute convictions that the subject inspires." 410 U.S. 113, 116 (1973) (emphasis added). And as recently as the 2000 *Stenberg* decision, this Court recognized "the controversial nature" of abortion, and that "[m]illions of Americans believe that life begins at conception and consequently that an abortion is akin to causing the death of an innocent child," *Stenberg v. Carhart*, 530 U.S. at 920.

Despite this Court's longstanding and insightful awareness of the good faith opposition to abortion by millions of Americans, including physicians, the district court treated the pro-life beliefs and associations of petitioners' experts as grounds for discounting the relative credibility of their testimony. This double standard, if upheld by this Court and applied by other federal district courts, would effectively relegate to second-class status the expert testimony of many physicians who would agree to testify in support of federal or state regulations and restrictions touching on the issue of abortion. Such a double standard must be rejected.

Categorically diminishing the value of the testimony of well-qualified medical experts merely on the basis of their principled opposition to abortion, while failing to factor in the self-interest of abortion providers who practice the very procedure at issue is blatantly unfair, undermines the perception of an unbiased judiciary, and effectively erects a *per se* and *a priori* rule discounting the testimony of every physician who respects and protects the life of their unborn patients before they ever step into a federal courtroom.

CONCLUSION

This Court should reverse the judgment of the Ninth Circuit.

Respectfully submitted,

JAMES L. HIRSEN
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Counsel for Amici Curiae

August 3, 2006

APPENDICES

Page

A. *Reargument of Roe v. Wade*, October 11, 1972 ..App. 1

B. *Declaration of Jack A. Andonie, M.D.* (Oct. 1, 1998) .....App. 4

C. *Declaration of Raymond Gasser, Ph.D.* (Oct. 1, 1998) .....App. 11

APPENDIX A

Excerpt from the Transcript of the reargument of *Roe v. Wade*, 410 U.S. 113 (1973) (Reargued on October 11, 1972). The entire transcript and audio file can be found at http://www.oyez.org/oyez/resource/case/334/reargument/transcript

* * *

JUSTICE MARSHALL: Is there any statute in Texas that prohibits the doctor from performing any operation, other than an abortion?

MR. FLOWERS: I don't – I don't think so, sir. And there is another thrust of our argument. If we declare, as the appellees in this case have asked this Court to declare, that an embryo or a fetus is a mass of protoplasm similar to a tumor, then of course the State has no compelling interest whatsoever.

JUSTICE MARSHALL: But there is no – the only operation that a doctor can possibly commit that will bring on a criminal penalty is an abortion?

MR. FLOWERS: Yes, sir.

JUSTICE MARSHALL: Why?

MR. FLOWERS: As far as –

JUSTICE MARSHALL: Well, why don't you limit some other operations?

MR. FLOWERS: Because this is the only type of operation that would take another human life.

JUSTICE MARSHALL: Well, a brain operation could.

MR. FLOWERS: Well, there again that would be – I think that in every feat that a doctor performs that he is constantly making this judgment.

JUSTICE MARSHALL: Well, if a doctor performs a brain operation and does it improperly, he could be guilty of manslaughter, couldn't he?

MR. FLOWERS: I would think so, if he was negligent.

JUSTICE MARSHALL: Well, why wouldn't you charge him with manslaughter if he commits an abortion?

MR. FLOWERS: In effect, Your Honor, we did, in the Statute 1195 that has been very carefully avoided all throughout these proceedings. It's not attacked as unconstitutional, for some reason. If you will permit me to –

JUSTICE MARSHALL: But is it at issue here?

MR. FLOWERS: No, sir. You asked the question about whether we had made manslaughter – or an abortion manslaughter.

JUSTICE MARSHALL: Maybe the reason is: Why have two statutes?

MR. FLOWERS: Well, this was in context with – this is 1195. They are attacking 1191 through 1196, but omitted 1195.

Here's what 1195 says – provides: "Whoever shall, during the parturition of the mother, destroy the vitality or life in a child in a state of being born, before actual birth and before actual birth – which child would have otherwise been born alive, which – shall be confined to the penitentiary for life, or not less than five years."

JUSTICE MARSHALL: *What does that statute mean?*

MR. FLOWERS: *Sir?*

JUSTICE MARSHALL: *What does it mean?*

MR. FLOWERS: I would think that –

JUSTICE STEWART: *That it is an offense to kill a child in the process of childbirth?*

MR. FLOWERS: *Yes, sir. It would be immediately before childbirth, or right in the proximity of the child being born.*

JUSTICE MARSHALL: *Which is not an abortion.*

MR. FLOWERS: *Which is not – would not be an abortion, yes, sir. You're correct, sir. It would be homicide.*

* * *

APPENDIX B

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF LOUISIANA

CAUSEWAY MEDICAL SUITE, et al,

PLAINTIFFS **Civil Action**

v.

No. 97-2211 "T"

MURPHY J. FOSTER, JR. Governor for the State of Louisiana, et al,

DEFENDANTS.

DECLARATION OF JACK A. ANDONIE, M.D.

I, Jack A. Andonie, M.D., declare under the penalty for perjury that the following is true:

1. I am a Clinical Professor in the Department of Obstetrics and Gynecology at LSU Medical School. I am board-certified in obstetrics/gynecology and I am the Founder of Lakeside Women's Specialty Center, Ltd. in Metairie, Louisiana. I received my Medical Degree from LSU Medical School in 1962. I serve as Medical Director at Lakeside Hospital and serve on the current board of the LSU Board of Supervisors. I teach and practice obstetrics-gynecology. I am a licensed medical doctor in the state of Louisiana. A more complete statement of my credentials and training are provided in my attached curriculum vitae. *See Attachment A.*

2. During the course of my thirty-six year medical career in obstetric/gynecology, I have examined and/or treated approximately twenty thousand women and delivered approximately ten thousand babies. I am a

medical expert in the areas of pregnancy, the process of birth, and birth. It is based upon my years of experience as a physician specializing in obstetrics and gynecology, my education, training, and the ongoing study of the relevant medical literature and statistical data normally relied upon by doctors of obstetrics and gynecology in their practices that I offer the following expert opinions.

3. Pursuant to a request by representatives of the Office of the Attorney General for the State of Louisiana, I have reviewed Act 906 of the 1997 Regular Session of the Louisiana Legislature (the "Act"), which creates "the crime of partial-birth abortion" La. R.S. 14:32.9(D). I have been asked to review the Act and offer my expert medical opinion on what the Act proscribes and whether or not a reasonable physician, upon reading the Act, will be sufficiently apprized of what is and what is not permitted under the Act.

4. The Act, with certain detailed exceptions (e.g., the life of the mother), proscribes what it refers to as "partial-birth abortion." The Act defines "partial-birth abortion" as

> the performance of a procedure on a female by a licensed physician or any other person whereby a living fetus or infant is partially delivered or removed from the female's uterus by vaginal means and with specific intent to kill or do great bodily harm is then killed prior to complete delivery or removal. La. R.S. 14:32.9(A)(1).

5. The plain language of the Act proscribes any procedure that is intended to kill an infant in the process of being born. By its very terms, then, the Act does not include within its proscription any abortion procedure.

6. Induced abortion is one method of terminating a pregnancy, the onset of the birth process is another.

7. Induced abortion is any procedure which causes fetal death *in utero,* thereby causing "the premature expulsion *from the uterus* of the products of conception." *Dorland's Illustrated Medical Dictionary* 4-5 (28th edition 1994) (Dorland's).

8. The process of birth begins, and complete birth is inevitable, once the membranes of the amniotic sac are ruptured, and the infant begins its emergence from the uterus through the cervical os (opening of the uterus) and into the vaginal canal.

9. The delivery or removal of any part of a living fetus from the uterus, beyond the cervical os, and into the vaginal canal after the membranes of the amniotic sac have been ruptured is a significant medical event – an event that is acknowledged under the Act. It is medically significant because pregnancy has ended and the process of birth has begun.

10. Pregnancy describes the locus where intrauterine fetal stasis is maintained. Pregnancy has never occurred or been maintained in the vaginal canal.

11. Because it is a medical fact that pregnancy is over (terminated) once the process of birth has begun, the Act's plain language regulates the birth process, not any abortion procedure. This is made plain because the Act proscribes the intentional killing of a living fetus or infant who has been *partially delivered or removed from the female's uterus by vaginal means.* In medical terms, the Act does not prohibit those procedures undertaken to terminate *pregnancy,* because the Act's terms address

specific intent to kill a living fetus or infant *after* the pregnancy has already been terminated.

12. Where the Act describes a "living fetus or infant [that] is partially delivered or removed from the female's uterus by vaginal means" it has, thereby, given effect to the medical distinction between (1) the locale where intrauterine fetal stasis is maintained (i.e., pregnancy) and (2) the dynamic irreversible process of birth. "Birth" is a process, not a single event. The birth process *begins* when the membranes of the amniotic sac are ruptured and the fetus emerges beyond the cervix into the vaginal canal, and *ends* with the complete separation from the mother.

13. By its own terms, then, the Act clearly regulates the process of birth which begins when the living fetus begins to exit the womb as described above. (The terms womb and uterus are synonymous. Dorlands at 1846 ("womb" is defined as "the uterus")).

14. The Act's plain language proscribes only those procedures wherein a living fetus (infant) is partially delivered or removed into the vaginal canal itself. A fetus or fetal part suctioned out through an enclosed vacuum tube running through the vagina would not, in medical terminology, be characterized as a fetus who is "partially delivered or removed from the female's uterus by vaginal means."

15. There is no question that the Act *does not* proscribe the destruction of a fetus *in utero,* i.e. abortion, because by its very terms the Act proscribes only those procedures designed to kill an infant that has been partially delivered out of the uterus at which point pregnancy has ended, the process of birth has begun, and abortion is no longer a medical possibility.

16. Though the term "partial-birth abortion" is not a medical term, it is descriptive of a medical procedure(s), as defined by the Act, that is practiced by some abortion doctors who refer to the procedure by various terms including "D&X," "intact dilation and extraction," "intact dilation and evacuation, "intact D&E," and "intact D&X."

17. Plaintiffs' own description of the "D&X procedure" would clearly qualify as a procedure prohibited by the plain terms of the Act:

> The intact D&E, "D&X," or "intact D&X" procedure is a variant of the traditional D&E procedure. . . . [T]he cervix is gradually dilated and the fetus is removed intact. . . . [T]he physician then creates a small opening at the base of the skull and evacuates some of the contents, allowing the calvarium [now emptied skull] to pass through the cervical opening. Alternatively, once the fetus is partially extracted, the physician crushes the skull with forceps. . . . The intact removal of the fetus is what distinguishes an intact D&E procedure from a traditional D&E procedure. [*Complaint* at ¶ 41.]

18. The Act proscribes doing "great bodily harm . . . " to "a living fetus or infant" that is "partially delivered. . . . " Medically speaking, you can do "great bodily harm" only to an intact "living fetus" or "infant." Therefore, a reasonable medical doctor reading the Act would understand "living fetus" and living "infant" to mean the living fetal (infant) organism as opposed to living fetal cells or dismembered fetal limbs or body parts.

19. Medical science recognizes that the living fetal (infant) organism is living if it shows signs of life, such as

beating of the heart, pulsation of the umbilical cord or movement of voluntary muscles.

20. The Act's plain language clearly does not proscribe the cephalocentesis procedure, which is removal of fluid from an enlarged head of a fetus with the most severe form of hydrocephalus. In such a procedure, a needle is inserted into the enlarged ventricle of the brain (the space containing cerebrospinal fluid). Fluid is then withdrawn which results in reduction in the size of the head so that delivery can occur. This procedure is not intended to kill the fetus, and, in fact, is often associated with the birth of a live infant. This is an important distinction between a needle cephalocentesis, which is intended to facilitate the birth of a living fetus, and the procedure described in the Act, which involves specific intent to kill a living fetus which has been partially delivered.

21. Upon reading the Act, a reasonable physician will certainly understand that destruction of the fetus *in utero*, i.e., abortion, remains protected in the law, and that the only procedure prohibited is partial delivery or removal of a living fetus or infant into the vaginal canal for the purpose of pausing the birth process to carry out a second step of intentionally killing the infant prior to complete delivery or removal.

I affirm under the penalties of perjury that the statements in my Declaration are true.

_____

Date

Jack A. Andonie, M.D.

Expert Witness Disclosure Required by Fed. R. Civ. P. 26(a)(2)(B)

1. The disclosure of my opinions, basis, reasons, data, qualifications are given in the attached affidavit.

2. My list of all publications within the last ten years is provided in the attached curriculum vitae.

3. My compensation is reasonable expenses, but no fee.

4. I have never before testified as an expert at trial or by deposition.

_____

Date Jack A. Andonie, M.D.

APPENDIX C

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF LOUISIANA

CAUSEWAY MEDICAL SUITE, ET AL.,

PLAINTIFFS Civil Action

v. No. 97-2211 "T"

MURPHY J. FOSTER, JR., ET AL.,

DEFENDANTS.

DECLARATION OF RAYMOND GASSER, PH.D.

I, Raymond Gasser, Ph.D., declare under the penalty for perjury that the following is true:

1. I am a Professor in the Department of Cell Biology and Anatomy at LSU Medical School (LSUMC), and, since 1980, I have been the course Director for Human Prenatal Development. I have been an Adjunct Professor of Obstetrics and Gynecology since 1994. I have been a member of the International Anatomical Nomenclature Committee since 1991 and I head the subcommittee on human embryological terms. Since 1991 I have been on the Advisory Committee, Human Developmental Anatomy Center, Armed Forces Institute of Pathology in Washington D.C. Also, since 1991 I have been Adjunct Curator for the Carnegie Collection of Human Embryos, Human Developmental Anatomy Center, Armed Forces Institute of Pathology, Washington D.C. My other credentials and experience are provided in my attached curriculum vitae. *See Attachment A – Curriculum Vitae.*

2. Based on my education, training, research, years of experience as a Professor of Anatomy and Ob/Gyn, personal knowledge, study of the relevant medical literature and statistical data recognized as reliable in the medical profession, I offer the following expert opinions.

3. Pursuant to a request by representatives of the Office of the Attorney General for the State of Louisiana, I have reviewed Act 906 of the 1997 Regular Session of the Louisiana Legislature (the "Act"), which creates "the crime of partial-birth abortion" La. R.S. 14:32.9(D). I have been asked to review the Act and offer my expert opinion on what the Act proscribes and whether or not a reasonable physician, upon reading the Act, will be sufficiently apprized of what is and what is not permitted under the Act.

4. The Act, with certain detailed exceptions (e.g., the life of the mother), proscribes what it refers to as "partial-birth abortion." The Act defines "partial-birth abortion" as

> the performance of a procedure on a female by a licensed physician or any other person whereby a living fetus or infant is partially delivered or removed from the female's uterus by vaginal means and with specific intent to kill or do great bodily harm is then killed prior to complete delivery or removal. La. R.S. 14:32.9(A)(1).

5. The Act is clear, in medical/anatomical terms, about the location of the "living fetus or infant" that cannot, with specific intent, be killed.

6. The clarity of the Act is manifest because by its very terms it describes a living fetus or infant who is in the process of being born.

7. A living fetus or infant is in the process of being born when he or she begins to emerge from the uterus through the cervical os into the vaginal canal, which occurrence denotes the medical fact that the inevitable and unstoppable process of birth has begun.

8. Because the Act addresses a procedure that involves specific intent to kill a living fetus or infant who has been intentionally partially removed from the uterus into the vaginal canal, the Act regulates the process of birth, not the induced abortion of an unborn fetus.

9. Induced abortion is one method of terminating a pregnancy, the onset of the birth process is another.

10. The significant medical distinction between pregnancy and the process of birth is best made by describing the anatomical structure of the woman with reference to the locus of the living fetus within that structure: *See Exhib. D-5, "Uterus, Vagina and Supporting Structures."*

a. The uterus is the muscular organ in a female in which a developing embryo and fetus is nourished.

b. The cervix is the neck of the uterus which opens into the vagina. The cervical os is the opening of the cervix.

c. The amniotic sac is the protective membrane between the cervical os and the vaginal canal.

d. The vagina is the canal in the female, extending from the vulva to the cervix.

As long as the fetus remains within the uterus a woman is pregnant. When, however, the membranes of the amniotic sac have been ruptured and any part of the living fetus or infant is delivered through the cervix, past the cervical os and into the vaginal canal, pregnancy has ended and the process of birth has begun.

11. The medical/anatomical distinction between pregnancy and the process of birth is underscored by the fact that pregnancy has never occurred or been maintained in the vaginal canal.

12. "Fetus" is the medical term to describe "the *unborn* offspring in the postembryonic period, after major structures have been outlined, in humans from nine weeks after fertilization until birth." DORLAND'S *ILLUSTRATED* MEDICAL DICTIONARY 617 (28th Ed. 1994). The term "fetus" means only the unborn child, not the umbilical cord or the placenta, although those structures are of fetal origin. *See Exhibit D-6, Lennart Nilsson photograph.*

14. Where the Act speaks of a "living fetus or infant that is partially *delivered or removed from the female's uterus by vaginal means*" it can, of medical/anatomical necessity, only mean that the living fetus or infant is removed from the uterus into the vaginal canal and does not include the suction of a fetus or fetal parts "into an enclosed suction cannula [tube]" running through the vagina.

15. In medical terms *fetus* means preborn human offspring 9 weeks after conception, and is expressly defined in the Act as meaning "the biological offspring of human parents."

16. *Infant*, as expressly defined in the Act means "the biological offspring of human parents." *Infant* is defined as " . . . human young from birth to 12 months; it includes the newborn or neonatal period." DORLAND'S *ILLUSTRATED* MEDICAL DICTIONARY 836 (28th Ed. 1994).

17. The Act proscribes doing "great bodily harm . . . " to "a living fetus or infant" that is "partially delivered. . . ." Medically/anatomically speaking, you can do "great bodily harm" only to an intact "living fetus" or "infant." Therefore, a reasonable medical doctor reading the Act would understand "living fetus" and living "infant" to mean the living fetal (infant) organism as opposed to living fetal cells or dismembered fetal limbs or body parts.

18. The fetal/infant organism is living if it shows signs of life, such as beating of the heart, pulsation of the umbilical cord or movement of voluntary muscles.

19. I have reviewed the artist's illustration that was used by Dr. Jack Andonie to explain partial birth abortion to the Louisiana House and Senate committees considering the Act at issue (a copy of which is attached hereto as "*Attachment B*"). It is my expert opinion that the illustration accurately depicts a baby 8-10 inches long, measured to scale to the doctor's hand. This corresponds exactly to the size of a baby during the 20-24 week range of pregnancy. Thus, the illustration accurately depicts the anatomical structures of the fetus, then partially born infant and female as described by Dr. Haskell in his 1992 paper entitled "Dilation and Extraction for Late Second Trimester Abortion." [*See* Defendants' Exhibit D-2].

20. Plaintiffs' own description of the "D&X procedure" mirrors the illustration described in paragraph 19 above and would clearly qualify as a procedure prohibited by the plain terms of the Act:

> The intact D&E, "D&X," or "intact D&X" procedure is a variant of the traditional D&E procedure. . . . [T]he cervix is gradually dilated and the fetus is removed intact. . . . [T]he physician then creates a small opening at the base of the skull and evacuates some of the contents, allowing the calvarium [now emptied skull] to pass through the cervical opening. Alternatively, once the fetus is partially extracted, the physician crushes the skull with forceps. . . . The intact removal of the fetus is what distinguishes an intact D&E procedure from a traditional D&E procedure. [*Complaint* at ¶ 41.]

21. A reasonable person reading the Act will have no doubt that he/she is prohibited only from intentionally killing a living fetus or infant that has been partially delivered into the vaginal canal.

I affirm under the penalties of perjury that the statements in my *Declaration* are true.

Date

_____

Raymond Gasser, Ph.D.

Expert Witness Disclosure Required by Fed. R. Civ. P. 26(a)(2)(B)

1. The disclosure of my opinions, basis, reasons, data, qualifications are given in the attached affidavit.
2. My list of all publications within the last ten years is provided in the attached curriculum vitae.
3. My compensation is reasonable expenses, but no fee.

4. I have testified as an expert at trial or by deposition in the following:

Date

Raymond Gasser, Ph.D.

392

MOTION FILED

SEP 1 - 2006

No. 05-1382

IN THE
SUPREME COURT OF THE UNITED STATES

ALBERTO R. GONZALES,
ATTORNEY GENERAL,

Petitioner,

v.

PLANNED PARENTHOOD
FEDERATION OF AMERICA,
INC., ET AL.

Respondents.

MOTION TO FILE AMICUS CURIAE BRIEF IN SUPPORT OF PETITIONER

MOTION TO FILE AMICUS CURIAE BRIEF OUT OF TIME

AMICUS CURIAE BRIEF
OF
RONALD W. MEYER

No. 05-1382

IN THE
SUPREME COURT OF THE UNITED STATES

ALBERTO R. GONZALES,
ATTORNEY GENERAL,

Petitioner,

v.

PLANNED PARENTHOOD
FEDERATION OF AMERICA,
INC., ET AL.

Respondents.

MOTION TO FILE AMICUS CURIAE BRIEF IN
SUPPORT OF PETITIONER

MOTION TO FILE AMICUS CURIAE BRIEF
OUT OF TIME

AMICUS CURIAE BRIEF
OF
RONALD W. MEYER

RONALD W. MEYER
Attorney at Law
3636 North Central Avenue
Suite 700
Phoenix, Arizona 85012
(602) 279-1663

COMES NOW, Ronald W. Meyer and pursuant to Rule 37 of the Rules of the Supreme Court, requests that he be given leave to file an *Amicus Curiae* Brief.

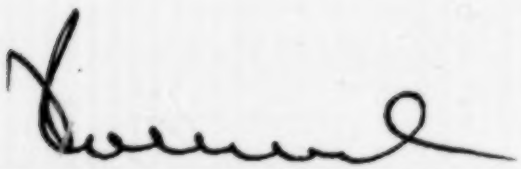
Pursuant to Rule 37 of the Rules of the Supreme Court, a request for consent to file the *Amicus Curiae* Brief was sent to Helene Krasman, Esq. of Planned Parenthood Federation of America, Inc. (Copy attached as Exhibit "A"). Planned Parenthood Federation of America, Inc. consented to filing the *Amicus Curiae* Brief (Exhibit "B").

A request for consent to file the *Amicus Curiae* Brief was sent to Paul D. Clement of the United States Department of Justice (Exhibit "C"). Paul D. Clement, on behalf of the United States Department of Justice declined to grant consent.

The issues raised in this *Amicus Curiae* Brief have not been addressed by the Petitioner, Respondent or any of the other *Amicus Curiae* Briefs.

DATED this 30th day of August, 2006.

LAW OFFICES OF RONALD W. MEYER



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(602) 279-1663

LAW OFFICES
OF
RONALD W. MEYER

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Ronald W. Meyer

August 25, 2006

VIA FAX ONLY: Fax No.: (202) 293-4349

Helene Krasman, Esq.
Planned Parenthood Federation of America, Inc.
1780 Massachusetts Avenue, N.W.
Washington, DC 20030

Re: Alberto R. Gonzales, Attorney General vs. Planned Parenthood Federation of America, Inc.
Supreme Court of the United States
Case No. 05-1382

Dear Ms. Krasman:

I am going to file an *amicus curiae* Brief on behalf of myself supporting the position of the Petitioner.

Pursuant to Rule 37 of the rules of the Supreme Court of the United States, I am requesting consent to file the *amicus curiae* Brief.

I realize that the Brief must be filed out of time, and that an appropriate Motion must be filed before the Supreme Court of the United States.

The Brief will be mailed for filing by Federal Express on or before September 1, 2006 and any consent would be conditioned upon filing the Brief by that time.

Sincerely yours,

RONALD W. MEYER

RWM/jg

EXHIBIT "A"

Planned Parenthood®
Federation of America, Inc.

434 West 33rd Street, New York, NY 10001
Phone 212.541.7800 • Fax 212.247.6811
www.plannedparenthood.org

Public Policy Litigation & Law

August 28, 2006

Via facsimile and U.S. Mail

Ronald W. Meyer
Law Offices of Ronald W. Meyer
3636 North Central Avenue
Suite 700
Phoenix, Arizona 85012
Fax No. (602) 222-4996

RE: Gonzales v. Planned Parenthood, Case No. 05-1382

Dear Mr. Meyer:

On behalf of Respondents Planned Parenthood Federation of America and Planned Parenthood Golden Gate in the above-captioned case, we consent to your request to file an amicus brief on behalf of the Petitioner out of time, provided that the brief will be mailed for filing by Federal Express on or before September 1, 2006, as stated in your request.

Sincerely,

Helene T. Krasnoff

EXHIBIT "B"

LAW OFFICES
OF
RONALD W. MEYER

3636 North Central Avenue
Suite 700
Phoenix, Arizona 85012
(602) 279-1663

Ronald W. Meyer

August 25, 2006

VIA FAX ONLY: Fax No.: (202) 514-8844

Paul D. Clement, Esq.
Solicitor General
United States Department of Justice
950 Pennsylvania Avenue, N.W.
Room 5614
Washington, DC 20530-0001
ATTN: Emily Spadoni

Re: Alberto R. Gonzales, Attorney General vs. Planned Parenthood Federation of America, Inc.
Supreme Court of the United States
Case No. 05-1382

Dear Ms. Spadoni:

I intend to file an *amicus curiae* Brief on behalf of myself in support of the position of the Petitioner.

Pursuant to Rule 37 of the Rules of the Supreme Court of the United States, I am requesting the Petitioner to consent to file the *amicus curiae* Brief.

Sincerely yours,

RONALD W. MEYER

RWM/jg

EXHIBIT "C"

No. 05-1382

IN THE
SUPREME COURT OF THE UNITED STATES

ALBERTO R. GONZALES,
ATTORNEY GENERAL,

Petitioner,

v.

PLANNED PARENTHOOD
FEDERATION OF AMERICA,
INC., ET AL.

Respondents.

MOTION TO FILE AMICUS CURIAE BRIEF IN SUPPORT OF PETITIONER

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No. 05-1382

IN THE
SUPREME COURT OF THE UNITED STATES

ALBERTO R. GONZALES,
ATTORNEY GENERAL,

Petitioner,

v.

PLANNED PARENTHOOD
FEDERATION OF AMERICA,
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Respondents.

MOTION TO FILE AMICUS CURIAE BRIEF OUT OF TIME

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COMES NOW, Ronald W. Meyer and requests this Court to grant leave to file an *Amicus Curiae* Brief out of time.

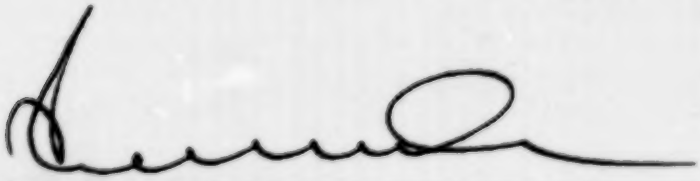
The *Amicus Curiae* Brief was due August 3, 2006, the date that the Brief of Petitioner was due. There is no prejudice to the Petitioner because its Brief has already been filed.

The Respondent, Planned Parenthood Federation of America, Inc. has consented to filing an *Amicus Curiae* Brief under the conditions set forth in its consent and will not be prejudiced by the late filing of the *Amicus Curiae* Brief.

The issues raised by the *Amicus Curiae* Brief are important and crucial to the Court's resolution of the issues raised in this case.

DATED this 30th day of August, 2006.

LAW OFFICES OF RONALD W. MEYER



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INTEREST OF AMICI CURIAE

Ronald W. Meyer is a citizen of the State of Arizona and a citizen of the United States of America and has a concern about living in a society which does not protect innocent human life and has an interest in the Courts properly applying the principles of *Roe vs. Wade*.

This is a brief in support of the Petitioner and in defense of the Partial Birth Abortion Ban Act of 2003.

No counsel for a party authored this *Amicus Curiae* Brief in whole or in part and no one other than the Amici Curiae has contributed money or services to the preparation or submission of this *Amicus Curiae* Brief.

SUMMARY OF ARGUMENT

This *Amicus Curiae* Brief raises two issues.

1. The Court in *Planned Parenthood Federation of America, Inc., et al. vs. Alberto R. Gonzales*, (9th C.A. 2006) 435 F.3d 1163, failed to properly apply the principles of *Roe vs. Wade*, 410 U.S. 113, 93 S.Ct 705, 35 L.Ed.2d 147 (1973), wherein this Court established that a woman does not have an absolute right to terminate her pregnancy at whatever time, in whatever way or for whatever reason, and that a State has an interest in protecting potential life.

2. The Court in *Planned Parenthood Federation of America, Inc., et al. vs. Alberto R. Gonzales*, (9th C.A. 2006) 435 F.3d 1163, failed to apply the

constitutional principle of balancing the rights of the State to protect potential life versus the right of privacy of the mother and failed to properly balance the right to life of the unborn child versus the right of privacy of the mother.

ARGUMENT

I

ROE VS. WADE

This Court in *Roe vs. Wade*, 410 U.S. 113, 93 S.Ct 705, 35 L.Ed.2d 147 (1973), clearly established that a woman does not have an absolute right to terminate her pregnancy at any time, in whatever way and for whatever reason that she alone chooses. The Court also clearly held that the State has an interest in protecting not only the health of the mother in maintaining medical standards but also in protecting potential life. Furthermore, the right of privacy cannot be absolute.

> "On the basis of elements such as these, appellant and some *amici* argue that the woman's right is absolute and that she is entitled to terminate her pregnancy at whatever time, in whatever way, and for whatever reason she alone chooses. With this we do not agree. Appellant's arguments that Texas either has no valid interest at all in regulating the abortion decision, or

no interest strong enough to support any limitation upon the woman's sole determination, are unpersuasive. The Court's decisions recognizing a right of privacy also acknowledge that some State regulation in areas protected by that right is appropriate. As noted above, a State may properly assert important interests in safeguarding health, in maintaining medical standards, and in protecting potential life. At some point in pregnancy, these respective interests become sufficiently compelling to sustain regulation of the factors that govern the abortion decision. The privacy right involved, therefore, cannot be said to be absolute. In fact, it is not clear to us that the claim asserted by some *amici* that one has an unlimited right to do with one's body as one pleases bears a close relationship to the right of privacy previously articulated in the Court's decisions. The Court has refused to recognize an unlimited right of this kind in the past. Jacobson v. Massachusetts, 197 U.S. 11, 25 S.Ct. 358, 49 L.Ed. 643 (1905) (vaccination); Buck v. Bell, 274 U.S. 200, 47 S.Ct. 584, 71 L.Ed. 1000 (1927) (sterilization)."

93 S.Ct. at Page 727,
410 U.S. at Page 153

Even thought the specific issue was not before this Court, this Court in *Roe vs. Wade* clearly indicated that the State interest in protecting potential future human life included regulating the surgical aspects of abortion in a more stringent manner or even to prohibit abortions in the later stages of pregnancy.

> "The asserted state interests are protection of the health and safety of the pregnant woman, and protection of the potential future human life within her. These are legitimate objectives amply sufficient to permit a State to regulate abortions as it does other surgical procedures, and perhaps sufficient to permit a State to regulate abortions more stringently or even to prohibit them in the late states of pregnancy."
>
> 93 S.Ct at Page 735
> 410 U.S. at Page 172

The decision in *Planned Parenthood Federation of America, Inc., et al. vs. Alberto R. Gonzales*, as well as previous cases has resulted in a situation where there is abortion on demand and that there is a total absence of any protection for the potential life of the unborn child. The State has been totally prohibited from exercising its interests in protecting that potential life.

Allowing the termination of a life that has all of the mental, emotional and physical attributes of a human being but is still in the womb of the mother rather than out of the womb of the mother violates the principles and spirit of *Roe vs. Wade*.

States and the United States Government, collectively referred to as States, have great latitude through the democratic process of their legislatures to define the type of society that citizens wish to reside in. Many states, like Arizona, have passed extensive laws protecting animals and preventing cruelty and reckless killing of animals.[1] The citizens of Arizona have decided that abusing animals and recklessly killing animals violates their sense of decency and they do not want to live in a society that would tolerate that conduct.

Ironically, a child which has all of the attributes of a human being that is only weeks away from delivery and therefore obtaining "person status" has less rights than a dog or a cat, and can be killed by grotesque procedures prohibited by the Partial Birth Abortion Ban Act. Under the Arizona Statutes, those procedures could not be used against animals.

Under the present status of the law, a person using the procedures of a partial birth abortion on a dog or a cat could be convicted of a felony crime but if performed on an unborn child is within the law.

---

[1] A.R.S. §13-2910.

Whether you believe that the unborn child is a human life or adopt the philosophy of the Planned Parenthood Federation of America, Inc. that the unborn child is potential life, the State has an interest and a right to protect that life from the abuse of the Partial Birth Abortion Ban Act.

Obviously, the limitation on the State's interest is the Constitutional Right of individuals. That raises the issue of who has Constitutional Rights. *Roe vs. Wade* was no help on this issue. In spite of undisputed medical evidence of the emotional, mental and physical development and capabilities of the unborn child, the Court held that an unborn child is not a person under the Constitution.

Decisions without a factual basis never resolve issues. The classic example is *Dred Scott vs.* Standford, 19 Howard 431, 15 L.Ed 691 (1857) wherein the Court held that a negro was not a person under the Constitution but was property. There is no more basis to hold that a negro is not a person under the Constitution as there is to hold that an unborn child is not a person under the Constitution.

The Court in *Roe vs. Wade* was reluctant to engage in theological discussions as to when life begins. Understanding that reluctance, this Court must address the issue of when life is protected under the Constitution. An artificial standard of whether the child is in or without the womb of the mother is totally inadequate in light of the advancing medical science and technology that is present today.

All persons concede that the unborn child is life. All persons concede that that life is at a minimum potential human life. Some contend that it is human life.

Besides recognizing that a State has an interest in protecting life, potential human life or human life, the Court must adopt a better definition of person which properly reflects the reality of that life.

II

BALANCING RIGHTS UNDER THE CONSTITUTION

The challenge of balancing the State interest in legislating in a particular area which affects the Constitutional Rights of an individual is no stranger to this Court.

For purposes of this Amicus Curiae Brief, one example will be cited. There is nothing more revered in this country than freedom of speech. Yet, no one would contend that the freedom of speech is absolute. This Court has been called upon to balance the rights of a State to regulate freedom of speech as part of its police powers to promote safety on streets and sidewalks, regulate the use of public areas, protect the privacy of other individuals, etc. *Huggins vs. Nashville Labor Relations Board*, 424 U.S. 507, 96 S.Ct. 1029, 47 L.Ed.2d 196 (1976). *Poulos vs. New Hampshire*, 345 U.S. 395, 73 S.Ct. 760, 97 L.Ed.1105 (1953).

The essential prerequisite in each case is that the Court must delineate the rights of the State versus the individual or the rights of the respective individuals and then applying constitutional principles balance those rights.

This Court would never sanction the resolution of freedom of speech by holding that a State has unlimited rights to inhibit speech or conversely, that a person has unlimited public free speech and can say anything anywhere, at anytime, under any circumstance.

Unfortunately, the Courts have taken this very approach in the abortion case. Contrary to accepted constitutional principles and contrary to the precepts of *Roe vs. Wade*, Courts subsequent to *Roe vs. Wade* have in effect held that the State has no interest in regulating any aspect of abortion other than the health of the mother and that the unborn child has no rights. This principle would not be acceptable in discussing other rights under the Constitution and should not be acceptable in dealing with rights of privacy and abortion.

CONCLUSION

1. This Court must reverse the Ninth Circuit in *Planned Parenthood Federation of America, Inc. vs. Alberto R. Gonzales* and hold that the State has a legitimate interest and right to regulate partial birth abortions and that the Partial Birth Abortion Ban Act of 2003 is constitutional and constitutionally balances

the interest of the State, the unborn child and the right of privacy of the mother.

2. This Court reestablished the principles of *Roe vs. Wade* that a woman does not have a right to abortion on demand and that the State has a right to protect human life or potential human life in the womb.

3. This Court established that life in the womb of a mother whether it be human or potential human life is entitled to some protection under the Constitution.

4. Establish a procedure that issues of abortion are resolved by balancing the rights of the State versus the privacy rights of a mother and the rights of an unborn versus the privacy rights of the mother.

Dated: August 30, 2006.

Respectfully submitted,

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PLANNED PARENTHOOD FEDERATION OF AMERICA, ET AL.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF THE THOMAS MORE SOCIETY, INC. AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

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INTEREST OF *AMICUS CURIAE*[*]

The Thomas More Society, Inc., is a non-profit, public interest law firm based in Chicago, Illinois. It was founded in 1997 to meet the burgeoning legal needs of the pro-life movement. Incorporated as a 501(c)(3) not-for-profit corporation under the laws of the State of Illinois, the Thomas More Society provides legal advice and assistance to those who face harassment, employment discrimination, unjust treatment, civil litigation or criminal prosecution as a result of their pro-life views or their peaceful protest activities. The Thomas More Society has provided legal services and assistance in a wide range of cases, including in this Court the representation of the named petitioners in *Scheidler v. NOW*, 537 U.S. 393 (2003), and *Scheidler v. NOW*, 125 S. Ct. 2991 (2006).

In addition to the legal representation it provides, the Thomas More Society supports appropriate public policy measures that are intended to protect innocent prenatal human life. Consistent with its core mission and the respect for human life that mission implies, the Thomas More Society respectfully submits this brief in support of petitioner the United States.

INTRODUCTION AND SUMMARY OF ARGUMENT

The issue presented in this case, as in *Gonzales v. Carhart*, No. 05-380, is whether the United States has the constitutional authority to ban an abortion procedure, variously described in the medical literature and trial testimony as "intact dilation and evacuation" (intact D&E) or "dilation and extraction" (D&X), that Congress has characterized as "gruesome and inhumane." Pub. L. No. 108-105, § 2(1), 117 Stat. 1201. In that procedure, a physician

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[*] Letters of consent have been filed with the Clerk. None of the counsel for the parties authored this brief in whole or in part, and no one other than *amicus* or its counsel has contributed money or services to the preparation or submission of this brief.

> deliberately and intentionally vaginally delivers a living, unborn child's body until either the entire baby's head is outside the body of the mother, or any part of the baby's trunk past the navel is outside the body of the mother and only the head remains inside the womb, for the purpose of performing an overt act (usually the puncturing of the back of the child's skull and removing the baby's brains) that the [physician] knows will kill the partially delivered infant, performs this act, and then completes the delivery of the dead infant . . . .

Id.

Based upon this Court's decision in *Stenberg v. Carhart*, 530 U.S. 914 (2000), the Ninth Circuit held that the Partial-Birth Abortion Ban Act of 2003 (the Act), 18 U.S.C. § 1531, which prohibits this procedure, except when necessary to save the life of the mother, is unconstitutional because it lacks a health exception and imposes an "undue burden" on women seeking pre-viability, second-trimester abortions. *See Planned Parenthood Federation of America v. Gonzales*, 435 F.3d 1163, 1171-81 (9th Cir. 2006). The court held further that the Act is unconstitutionally vague. *Id.* at 1181-84. For the reasons set forth in the Solicitor General's brief, the Ninth Circuit's principal holding – that the Act is unconstitutional because it lacks a health exception – is erroneous and should be reversed.[1]

---

[1] *Amicus* emphasizes one point with respect to the health issue. Even assuming that, for some women, an induction may be contraindicated, that for other women, a dismemberment D&E may not be appropriate, and that for yet still other women, it may not be possible to cause "fetal demise" before beginning an intact D&E, respondents failed to identify any circumstances in which *all three alternatives* to performing an intact D&E on a living fetus would be contraindicated, inappropriate or impossible. Respondents' failure to identify such circumstances is fatal to their argument that an intact D&E performed on a living fetus is ever necessary to preserve the woman's health, in either an absolute or even a relative sense.

Rather than address the court's flawed principal holding, *amicus* addresses the court of appeals' alternative holdings.

1. *Undue Burden.* The court of appeals held that the Act imposes an "undue burden" on women seeking pre-viability, second-trimester abortions in violation of *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), because its definition of "partial-birth abortion"[2] includes not only intact D&Es, but also other second-trimester abortion procedures – such as dismemberment D&Es and inductions – which account for almost all abortions performed in the second trimester. *See* 435 F.3d at 1176-81. That holding cannot be reconciled with the language or structure of the Act.

By its plain terms, the Act applies only if a physician "deliberately and intentionally" vaginally delivers a living fetus – not *parts* of a fetus – beyond the anatomical markers set forth in the Act (18 U.S.C. § 1531(b)(1)(A)); only if the physician does so "for the purpose of performing an overt act" that he or she knows will kill the fetus (*id.*); only if the physician then performs such an overt act, other than completion of delivery (*id.* § 1531(b)(1)(B)); and only if the physician does all of this "knowingly," rather than by accident or happenstance (*id.* § 1531(a)). The conduct described in the definition of "partial-birth" abortion," together with the *scienter* requirements of the Act, effectively exclude dismemberment D&Es and inductions.

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[2] The Act prohibits a physician from "knowingly" performing a "partial-birth abortion," 18 U.S.C. § 1531(a), which is defined as "an abortion in which the person performing the abortion – (A) deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and (B) performs the overt act, other than completion of the delivery, that kills the partially delivered living fetus." 18 U.S.C. § 1531(b)(1).

In neither procedure does the physician have the specific intent, *at the outset of the procedure*, to deliver the fetus intact for the purpose of performing an overt act that will kill the fetus after it has been partially delivered. Nor does the Act apply when, during the course of a standard D&E or induction, the physician discovers that he or she must perform an overt act that kills the partially delivered fetus in order to complete delivery.

2. *Vagueness*. The court of appeals held that three terms used in the Act – "partial-birth abortion," "living fetus" and "overt act" – are impermissibly vague. *See* 435 F.3d at 1181-84. That holding is also erroneous. Whether the term "partial-birth abortion" has a recognized meaning, apart from the Act, is of no consequence, because it is clearly and carefully defined in the Act itself. The term "living fetus" means a fetus with a heartbeat, as respondents' expert witnesses recognized. Finally, the term "overt act," in context, refers to an act that the physician knows will kill the fetus after it has been delivered beyond the anatomical markers set forth in the Act, distinct from those acts (*e.g.*, cutting the umbilical cord) that are required to complete delivery. Individually as well as collectively, then, the challenged terms used in the Act "give the person of ordinary intelligence a reasonable opportunity to know what is prohibited, so that he may act accordingly." *Grayned v. City of Rockford*, 408 U.S. 104, 108 (1972).

3. *Impact of the Act*. In addition to being foreclosed by the text and structure of the Act, the court of appeals' "undue burden" and vagueness holdings are refuted by official abortion reporting statistics from several States whose partial-birth abortion acts were not enjoined prior to this Court's decision in *Stenberg*. Review of these statistics reveals that enactment of such laws did *not* prevent physicians from performing dismemberment D&Es and inductions. This, in turn, suggests that respondents' alleged fear that enforcement of the Partial-Birth Abortion Ban Act would "chill" physicians from performing conventional second-trimester abortion procedures is baseless.

ARGUMENT

I.

THE PARTIAL-BIRTH ABORTION BAN ACT DOES NOT IMPOSE AN UNDUE BURDEN ON WOMEN SEEKING PRE-VIABILITY, SECOND-TRIMESTER ABORTIONS.

In their complaint, respondents alleged that "the term 'partial-birth abortion' . . . is defined so broadly in the Act as to chill physicians from providing the safest and most common methods of abortion used in the second trimester of pregnancy prior to viability," and thus "imposes an 'undue burden' on the right to obtain previability abortions." Supp. Cplt. at 2, ¶ 4. *See also id.* at 3-5, ¶¶ 9-10. Respondents alleged that a "partial birth-abortion," as defined in the Act, "could occur in any D&E abortion, including, but not limited to intact D&E abortions, as well as in any induction abortion," *id.* at 8-9, ¶ 25, which, taken together, "account for more than 95% of pre-viability abortions performed in the second trimester of pregnancy." *Id.* at 9, ¶ 27. "While not all D&E or induction abortions will proceed in a manner that violates the Act, physicians cannot know or predict in advance which abortions will so proceed. Performing any D&E or induction abortion thus places doctors at risk of violating the Act." *Id.* at 9, ¶ 26. "If the Act were to take effect [respondents] would be chilled from providing D&E or inductions abortions because of the reasonable fear of criminal prosecution and civil liability under the Act." *Id.* at 10, ¶ 29. The Act "imposes an undue burden on women seeking second-trimester abortions," *id.*, which violates their right to privacy and liberty guaranteed by the Due Process Clause of the Fifth Amendment." *Id.* at 12, ¶ 39 (Second Claim for Relief).

Respondents' medical experts testified (at trial or in designated portions of discovery depositions that were admitted into evidence) that the Act *would* prevent them from performing intact D&Es and, depending upon the circumstances, *could*

prevent them from performing standard (dismemberment) D&Es, as well.[3] Drs. Broekhuizen, Grunebaum and Hammond testified that the Act would also prevent them from performing at least some inductions.[4] The court of appeals agreed with respondents' "undue burden" claim and, in the alternative, struck down the Act on this ground. *See* 435 F.3d at 1176-81.

The Ninth Circuit's conclusion – and the testimony of respondents' medical experts concerning the purported scope of the Act's prohibitions – rest on a fundamental misunderstanding of the statutory language, however. Properly interpreted, the Act simply does not apply to procedures other than intact D&Es. Physicians who perform standard (dismemberment) D&Es and inductions do not "deliberately and intentionally" deliver the fetal head or trunk outside the mother's body "for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus." 18 U.S.C. §

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[3] *See* Tr. 50, 74-80 (Paul); 199-202 (Sheehan); 281-83, 334 (Drey); 420-22, 425-26 (Doe); 551-52 (Broekhuizen); 656-57 (Creinin); 822-24 (Westhoff); 1787-88 (Chasen); Hammond Dep. 200:7-15. *See also* Plaintiffs' Exh. 36 (Frederiksen Exp. Rep.), at 3-4. Dr. Grunebaum no longer performs second-trimester abortions because he does not believe that the language of the Act is clear and he does not know whether he is covered by the injunctions that have been issued in the cases challenging the Act. *See* Grunebaum Dep. 31:25-32:8; 160:24-161:18; 167:1-21; 223:14-224:3; 236:8-15.

[4] *See* Tr. 551-53 (Broekhuizen); Grunebaum Dep. 224:6-7; Hammond Dep. 327:6-11. Dr. Frederiksen made the same claim in her expert report. *See* Plaintiffs' Exh. 36, at 4. Three other experts who testified for respondents–Drs. Drey, Chasen and Doe–perform induction abortions, as well as D&Es. Dr. Drey and Dr. Chasen, however, expressed no opinion on the impact of the Act on their performance of inductions. *See* Tr. 281-84; 334 (Drey); 1788 (Chasen). Dr. Doe did offer an opinion on the subject, but the district court sustained the Government's objection to his opinion because it was not discussed in his expert report. *See* Tr. 423-25.

1531(b)(1)(A). A standard D&E contemplates dismemberment (through traction at the internal cervical os) and fetal death while the fetus itself is within or almost entirely within the mother's body. *See Stenberg*, 530 U.S. at 924-27. And induction merely involves induced premature delivery of a fetus, which results in the death of the fetus without the need for any overt act, other than completing the delivery. Neither procedure is undertaken with the specific intent, when it begins, of causing partial delivery of a living fetus outside the mother's body for the purpose of performing an overt act that the physician knows will kill the fetus after such partial delivery. Thus, neither procedure falls within the scope of the Act.

Moreover, the circumstances that *could* lead to any purported need to kill a fetus to complete a vaginal delivery *after* a standard (dismemberment) D&E abortion or induction has begun are simply circumstances that *might* occur, but are not *planned* as part of either procedure (as the Act clearly requires). If such circumstances happen to develop during the performance of a standard D&E or induction, or even if they are foreseen, physicians may cause fetal death after the fetus has been partially delivered without violating the Act. This is so because, *at the outset of the procedure*, they did not "deliberately and intentionally" partially vaginally deliver the fetus outside the mother's body (beyond the anatomical markers specified in the Act) "for the purpose of performing an overt act [other than completing delivery]" that they knew would kill the partially delivered fetus. 18 U.S.C. § 1531(b)(1)(A).

Dilation and Evacuation Procedures

Most of respondents' expert witnesses testified that an intact D&E is simply a variation of a standard D&E and not a distinct procedure.[5] Dr. Creinin, however, testified that an

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[5] *See* Tr. 44, 45, 71 (Paul); 458 (Doe); 521 (Broekhuizen); 795, 807 (Westhoff); 1710, 1826 (Chasen); Grunebaum Dep. 66:3-5;

intact D&E (or D&X) *is* a distinct procedure from a D&E (but one which he does not currently perform). Tr. 736-37. But whether an intact D&E is only a variation of a standard D&E or is a separate procedure, it has certain characteristics that distinguish it from a standard D&E in which the fetus is dismembered during the course of the abortion. Those characteristics, along with the *scienter* requirements specified by the Act, provide a principled basis for distinguishing between intact D&Es and dismemberment D&Es – and for prohibiting the former (when performed with the requisite intent) but not the latter.

First, as respondents' experts generally agreed, intact D&E generally requires more dilation of the cervix, usually over the course of several days, to allow the physician to extract the fetus intact (up to the head, in a breech presentation),[6] than is required to remove the fetus in parts with forceps in a

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214:11-16; Frederiksen Dep. 28:23-24. *See also* Tr. 205 (Sheehan) ("I don't differentiate those two procedures"); Hammond Dep. 94:14-15 ("the fact is a D&E is a D&E is a D&E"); *see also id.* at 95:21-96:17.

[6] There is no evidence in the record that any of the respondents' witnesses ever performs an "overt act" to cause the death of the child *after* its head has completely emerged from the mother's body in a D&E. If the fetus presents in a vertex (head first) or transverse (sideways) position, it is usually converted to a breech position. *See* Tr. 405-06 (Doe); 515-16 (Broekhuizen); 667, 669 (Creinin); 827-29 (Westhoff); 1724-25 (Chasen). In Dr. Chasen's study of intact D&Es, in the few instances in which a vertex presentation was not converted to a breech, fetal death was caused *before* the head was completely outside the mother's body. Tr. 1741-42 (Chasen). *See also* Tr. 761-62 (Creinin) (same in his experience); Frederiksen Dep. 49:12-18 (same). The Act would not apply in such cases.

standard D&E.[7] In Dr. Broekhuizen's words, the greater degree of cervical dilation is the "critical difference" between intact D&E and dismemberment D&E. Tr. 544. Second, intact D&E calls for a different use of instruments and technique. Unlike a standard D&E, in which forceps with serrated inside edges are used in a "twisting" or "rotating" motion to grasp and crush tissue to dismember the fetus at the internal cervical os, in an intact D&E physicians use little or no instrumentation in the uterus and apply "gentle traction" in order to bring the fetus through the cervix intact (or largely intact), at which point an overt act is performed that causes death.[8] Third, in a standard D&E, the physician does not generally know at what stage of the procedure the fetus dies,[9] whereas in an intact D&E, he or

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[7] *See* Tr. 55, 57, 71 (Paul); 165-66, 182-83, 193, 206, 241-42 (Sheehan); 281-82 (Drey); 437 (Doe); 507-08, 518-20, 522, 588 (Broekhuizen); 678, 685, 735, 738-39 (Creinin); 835-37 (Westhoff); 1723 (Chasen) ("In cases in which I am able to do an intact – the intact variation of D&E, those patients tend to have more dilation than patients in whom I must resort to forceps"); Frederiksen Dep. 28:24-29:4. Dr. Hammond implied that the dilation required for to remove the fetus intact is greater than that needed simply to pass instruments through the cervix in a disarticulation D&E. *See* Hammond Dep. 72:18-73:1, 103:22-104:9, 136:2-8. *See also* Grunebaum Dep. 72:3-15; 102:22-103:22; 167:22-168:3 (degree of dilation makes a difference in what options are available).

[8] Tr. 70-71 (Paul); 224-25, 229-35 (Sheehan); 435-36 (Doe); 519, 567-71 (Broekhuizen); 666-668, 740 (Creinin); 837 (Westhoff); 1721, 1759 (Chasen); Grunebaum Dep. 83:11-21; 90:17-91:2; 94:1-14; 106:6-113:23 (describing intact D&E); 150:19-151:14 (in an intact D&E "no instrument . . . enters the uterus"); 165:25-166:17; 175:25-176:3; 213:21-214:6.

[9] *See* Tr. 73 (Paul); 187 (Sheehan); 282 (Drey); Grunebaum Dep. 85:5-21; 125:23-126:1. *See also* Plaintiffs' Exh. 36 (Frederiksen Exp. Rep.), at 4 (in a D&E, "I am unaware of when the fetal heart stops beating").

she knows that it is the act of separating the head from the body, crushing the head with forceps or puncturing the base of the head with a sharp instrument and suctioning (or draining) its contents that causes the death of a fetus that was alive at the beginning of the procedure.[10] It is precisely *because* an intact D&E has distinctive characteristics that differentiate it from a standard D&E that respondents' experts were able to describe it in a leading textbook on abortion practice, teach it as a procedure in medical school and study its relative safety.[11]

Respondents' experts testified that, before performing a standard D&E, they cannot usually predict whether the fetus

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[10] *See* Tr. 512 (Broekhuizen); 823 (Westhoff); 1783-84 (Chasen); Grunebaum Dep. 126:2-4; 127:2-4; 230:13-19; Frederiksen Dep. 28:23-29:17. *See also* Plaintiffs' Exh. No. 36 (Frederiksen Exp. Rep.), at 4 (physician knows that the fetus will not survive an overt act compressing its head). Physicians who do not intend to perform an intact D&Es also recognize that these acts cause death. *See* Tr. 73 (Paul); 422 (Doe).

[11] Dr. Paul's standard reference text on abortion, "A Clinician's Guide to Medical and Surgical Abortion," includes a separate section on "intact D&E." Tr. 11-12, 44 (Paul). Both Dr. Westhoff and Dr. Chasen teach the intact variation of D&E at their university medical centers. *See* Tr. 795, 831-32 (Westhoff); 1711-12 (Chasen). Intact D&E is also taught at a number of other universities and medical colleges. *See* Tr. 832 (Westhoff). And Dr. Chasen was able to design and conduct a "retrospective cohort study" of 383 patients (Plaintiffs' Exhibit No. 19) comparing the relative safety of intact D&E, referred to in the study as "intact dilation and extraction," with disarticulation (dismemberment) D&E at 20 weeks or greater gestational age. Tr. 1735-39, 1742. The study differentiated between "disarticulation with forceps" and "intact extraction," in which the fetus was removed intact up to the head or, in a handful of cases, when the fetus had already died, and disarticulation without forceps occurred after the lower extremities and pelvis had been removed. Tr. 1740-41.

will be removed substantially intact or disarticulated.[12] In their experience, however, removal of an intact (or largely intact) fetus is the exception, not the rule.[13] And even in those

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[12] *See* Tr. 71, 121 (Paul); 206-07, 235 (Sheehan); 406-07, 420, 426, 436, 455, 458, 462-63 (Doe); 522 (Broekhuizen); 681, 786 (Creinin).

[13] *See* Tr. 71 (Paul) (5-10% of second-trimester D&Es); 571 (Broekhuizen) (same); 273 (Sheehan) (one out of every fifteen second-trimester D&Es); 432 (Doe) (15% of second-trimester D&Es, of which 80% were partially delivered and 20% were completely delivered without further instrumentation); 681, 731 (Creinin) (once a month, or slightly more than 2% of the 500 abortions he performed in a recent year). Out of 5,000 D&E abortions Dr. Creinin has performed, the fetus has been delivered intact up to the head before becoming lodged at the internal cervical os on only 50 occasions. *See* Tr. 732, 744-47. In Dr. Hammond's experience, it happens only three times a month. *See* Hammond Dep. 113:2-24. Out of the hundreds of D&Es she has performed, Dr. Frederiksen was unable to state whether she has performed even twenty intact D&Es (or intact D&Xs). *See* Frederiksen Dep. 25:5-8; 26:7-9; 31:6-12; 32:3-6. These physicians generally expect that the abortion will proceed as a dismemberment D&E. *See* Tr. 223 (Sheehan) ("The procedure that we use is generally disarticulation and crushing maneuvers to get the fetus small enough to fit through the aperture"), 221-23 ("routine" D&E "usually" involves disarticulation), 235 (disarticulation "is what we generally do"); 435 (Doe) (common characteristic of a D&E is disarticulation); Hammond Dep. 90:21-01:12 (in "most D&Es," the fetus is disarticulated in parts), *id.* at 81:18-21 (in performing a D&E, Dr. Hammond "extract[s] portions of the fetus with *repeated* insertions of the extraction forceps") (emphasis added). In her expert report, Dr. Frederiksen stated that "When performing D&E abortions, . . . at least some degree of dismemberment in often required." Plaintiffs' Exh. 36, at 2. In describing a standard D&E to his patients, Dr. Broekhuizen informs them that he will use suction methods and instruments "to remove the fetus in parts." Tr. 510, 567. Dr. Creinin also informs his patients that the fetus will be removed "in parts." Tr. 739-40.

exceptional cases, respondents' experts, in performing a standard D&E, attempt to complete delivery without causing the death of the fetus by an overt act after the fetus has partially emerged from the mother's body beyond the anatomical markers specified in the Act.[14] It is only if the fetus cannot be completely delivered without further intervention that these physicians perform an overt act that causes the death of the fetus.[15] But that conduct does not bring them within the scope of the Act because it was not their intent, *at the outset of the procedure*, to deliver a living fetus partially outside the mother's body for the purpose of performing an overt act that they know would kill the fetus before completing delivery. Rather, their intent was, in the first instance, to deliver the fetus

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[14] *See* Tr. 60-61, 67-68, 71 (Paul); 193, 241-42 (Sheehan); 405, 432 (Doe); 511-12, 523 (Broekhuizen); 747 (Creinin) (referring to five to ten "surgical transvaginal abortions" performed between the sixteenth and twenty-four weeks of pregnancy in which the fetus was removed intact without Dr. Creinin having to collapse the skull). At or near twenty-four weeks' gestation, however, Dr. Creinin takes steps to avoid the delivery of a live baby, including holding the head of the fetus on the internal side of the cervical os in order to collapse the skull, even if the entire fetus could have passed through the cervix without having its head compressed. *See* Tr. 747-48. Dr. Frederiksen testified that it is "preferable" to remove the fetus intact without compressing the head. Frederiksen Dep. 30:5-14. Dr. Hammond testified that it would be "desirable" in a D&E "to remove the entire fetus intact from inside through the cervix out of the body without disarticulation, decompression or any other maneuver," although, in his experience, that has never been possible with a live fetus. Hammond Dep. 104:10-23. With induction procedures, when fetal demise has not been caused beforehand by an injection of digoxin or potassium chloride, Dr. Hammond never takes steps to kill the fetus during or after the procedure. If the fetus is born alive, he provides appropriate comfort care for the baby. *Id.* 184:4-17.

[15] *See* Tr. 61, 70 (Paul); 193, 206, 235 (Sheehan); 405, 433 (Doe); 512, 523-24 (Broekhuizen); 680-81, 744-46 (Creinin).

vaginally *without* performing an overt act that would cause its death *after* it had been partially delivered.

Intent at the time the procedure begins, then, is key to liability under the Act (along with performance of the conduct described therein). Unlike physicians who perform standard D&Es, Dr. Westhoff and Dr. Chasen, as a routine part of their abortion practice and in their teaching, perform second-trimester D&Es with the express intention, at the outset of the procedure, of delivering an intact fetus beyond the anatomical markers set forth in the statute, for the purpose of performing an overt act that they know will cause the death of the fetus after it has been partially vaginally delivered. *See* Tr. 795, 801-02, 805, 816-17, 823 (Westhoff); 1710-12, 1722 (Chasen).[16] In contrast to the practice of Drs. Paul, Sheehan, Doe, Broekhuizen, Hammond and Frederiksen and, in certain circumstances, Dr. Creinin, in performing standard D&Es (*see* note 14, *supra*), neither Dr. Westhoff nor Dr. Chasen allows a *partially* delivered fetus to be *completely* delivered without causing its death by an overt act. *See* Tr. 817, 823 ("at that point I will perform one or more acts . . . that I know will kill the fetus") (Westhoff); 1783-84 (Chasen) (same).[17]

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[16] As did Dr. Grunebaum, before he stopped performing abortions. *See* Grunebaum Dep. 88:5-91:2; 95:17-96:21; 106:6-113:23.

[17] *See also* Grunebaum Dep. 96:23-97:17 (Dr. Grunebaum has never performed an intact D&E on a live fetus when the entire fetus was delivered "head to toe" without having its brains suctioned out while its head was lodged at the internal cervical os). Along with Dr. Creinin's chilling testimony that "the purpose of my act is to kill the partially-delivered living fetus because that's the objective of the abortion," Tr. 683, this practice raises disturbing questions about the nature of the "abortion liberty." Is it the right not to be pregnant anymore? or the right to a dead baby when a living (if not viable) baby could have been delivered without in any way endangering the

Moreover, again unlike physicians performing standard D&Es, who do *not* take any special steps to ensure that the fetus will be delivered intact,[18] both Dr. Westhoff and Dr. Chasen employ distinctive maneuvers in performing an intact D&E and both provide significantly greater dilation of the cervix than they would in performing a standard D&E at an earlier stage of pregnancy. *See* Tr. 836-40 (Westhoff); 1723 (Chasen).[19] As a result, Dr. Westhoff, succeeds in performing an intact D&E in one-third to one-half of the cases in which she intends to perform the procedure (after the 19th or 20th week of gestation),

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mother's life or health? Both Dr. Broekhuizen (Tr. 610-11) and Dr. Westhoff (Tr. 847-49) testified that when an abortion is indicated because of maternal health conditions, it is never medically necessary to kill the fetus in the process. In *Wynn v. Scott*, 449 F. Supp. 1302 (N.D. Ill. 1978), *appeal dismissed*, 439 U.S. 8 (1978), *aff'd sub nom. Wynn v. Carey*, 599 F.2d 193 (7th Cir. 1979), the district court held that, when a physician has a choice of procedures, both of equal risk to the woman, the State may, without interfering with the woman's right to terminate her pregnancy, require the physician to use that procedure "which is least likely to kill the fetus." 449 F. Supp. at 1321. The court explained, "*It never could be argued that she has a constitutionally protected right to kill the fetus. She does not.*" *Id.* (emphasis added).

[18] *See* Tr. 435-36 (Doe); 520 (Broekhuizen); 685 (Creinin). *See also* Tr. 205 (Sheehan) (suggesting that whether the fetus emerges intact is a matter of happenstance). Dr. Sheehan has never performed an intact D&E, as it has been described by the American College of Obstetricians & Gynecologists. *See* Tr. 213. Dr. Creinin has performed an intact D&E only three times, *see* Tr. 736, 784, but never with that intent at the beginning of the procedure. *See* Tr. 766 ("I didn't set out to do it, but it happened that way").

[19] *See also* Grunebaum Dep. 58:24-59:6; 72:6-9 (same). Given adequate dilation, Dr. Grunebaum has a choice to do "an extraction D&E or a dismemberment D&E." *Id.* 212:21-213:4.

see Tr. 819, 836,[20] which is a significantly higher percentage than is reflected in the experience of those physicians who do not set out to perform intact D&Es and who do not take any special steps to ensure that the fetus *will* be delivered intact. *See* note 13, *supra* (indicating that the fetus is partially vaginally delivered intact in only one to twelve percent of the second-trimester D&Es that they perform).

In addition to Dr. Westhoff and Dr. Chasen (and Dr. Grunebaum, when he performed abortions), Dr. Broekhuizen, on very rare occasions, has used his "serial dilitation [dilation]" technique as an alternative to "the traditional D&E-type method," in a manner that would violate the Act. Tr. 536. *See also* Tr. 588. With that technique, Dr. Broekhuizen dilates the cervix with laminaria every four to six hours until he has achieved enough dilation to extract the fetus. Tr. 538. At that point, if there is sufficient dilation for only partial, as opposed to total, extraction, he "compress[es] and decompress[es]" the head of the fetus to complete the procedure. Tr. 538. On two of the three occasions in which he intended to use this technique,[21] the fetus was delivered completely intact without Dr. Broekhuizen having to "compress" or "decompress" the fetal

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[20] Dr. Grunebaum reported the same results. *See* Grunebaum Dep. 47:14-20 (one-half to two-thirds of the 100 D&Es he performed in a recent three year period were *not* intact D&Es, implying that one-third to one-half *were* intact D&Es). Dr. Chasen did not quantify how often he succeeds in attempting to perform intact D&Es, perhaps because he performs only three to five abortions per month. *See* Tr. 1710.

[21] One case involved a patient who had scleroderma with pulmonary hypertension and vascular disease; the other involved a patient whose fetus had a lethal anomaly, skeletal dysplasia (a form of dwarfism). *See* Tr. 537, 539. 591-92, 598-600. Dr. Broekhuizen uses his "serial dilitation" technique whenever he intends to deliver the fetus intact to the head. Tr. 588-59.

head. Tr. 538-40. Nevertheless, in choosing this abortion method in these two instances, his *purpose* was to deliver the fetus intact only up to the head, a method he called "intact D&E," or "D&X." Tr. 588-90, 600. On the third occasion, involving a fetus "with a lethal chromosomal anomaly and significant macrocephaly [or "hydrocephaly," an enlarged head caused by excess fluid in the skull, Tr. 603] that clearly was incompatible with survival," Dr. Broekhuizen induced labor with serial dilation of the cervix, delivered the fetus until its head lodged at the internal cervical os, then inserted a thin trocar (a hollow instrument with a sharp edge, *see* Tr. 524) into the base of the skull, drained the fluids and brain tissue, collapsed the skull with forceps and completed the delivery. Tr. 540-42, 602-03, 606. The fetus was alive when its head lodged at the internal os. Tr. 542. Dr. Broekhuizen acknowledged, however, that in certain circumstances excess fluid may be removed with a needle without causing the death of the fetus. *See* Tr. 603-06.[22] In sum, when it is given its proper construction, the Partial-Birth Abortion Ban Act applies only to physicians who intend, *at the beginning of an abortion procedure*, to perform an intact D&E – the Act does *not* apply to physicians who perform dismemberment D&Es.

Induction Procedures

Respondents claimed that physicians who perform induction abortions could be found to have violated the Act, at least in certain circumstances. *See* Supp. Cplt. at 8-11, ¶¶ 25-27, 29, 31. This case, however does not provide the Court with an appropriate vehicle for determining what effect, if any, the

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[22] Dr. Broekhuizen mentioned that on one or two other "rare" occasions, he had patients who were opposed to induction but wanted an intact fetus for autopsy purposes. Tr. 540. He admitted, however, that compression (or decompression) of the head in these circumstances would destroy the brain and preclude the ability to examine the brain for any pathological analysis. *See* Tr. 581-82

Act has with respect to the performance of induction abortions and, if so, whether that effect is constitutional. Planned Parenthood Federation of America does not provide any medical services. *See* Tr. 130-31 (Craig). Planned Parenthood Golden Gate, the other original plaintiff, does not perform inductions at any of their clinics. *See* Tr. 10 (Paul). Neither respondent alleged that it offers induction procedures. *See* Supp. Cplt. at 3-4, ¶¶ 9, 10. Inductions *are* performed in facilities operated by the City and County of San Francisco, the intervening plaintiff, but in describing the impact of the Act on their services, Dr. Drey mentioned only D&Es, not inductions. *See* Tr. 281-84, 334. Four of respondents' expert witnesses – Drs. Broekhuizen, Hammond, Grunebaum and Frederiksen – perform inductions and testified (or stated in their expert reports) that the Act could affect such procedures.[23] None of them, however, is employed by or performs abortions for the respondents.[24] It was improper, therefore, for the lower courts to consider whether the Act could apply to inductions. In any event, their resolution of this issue was erroneous.

In an induction, the fetus is normally delivered completely intact without the necessity of performing an overt act that kills the fetus after it has been delivered past the anatomical markers specified in the Act. It is the rare situation when, in a breech presentation, the head of the fetus lodges at the internal cervical os and cannot be removed without being compressed or having

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[23] *See* Tr. 551-53 (Broekhuizen); Hammond Dep. 327:6-329:11; Grunebaum Dep. 224:6-14; Plaintiffs' Exh. 36 (Frederiksen Exp. Rep.), at 4. Dr. Chasen performs inductions, but offered no opinion on the effect of the Act on inductions. Dr. Doe's opinion was excluded. *See* note 4, *supra*.

[24] Dr. Broekhuizen is the part-time medical director of Planned Parenthood of Wisconsin (which is not a respondent in this case), but he does not perform abortions at any of their facilities. *See* Tr. 486-88 (Broekhuizen).

its contents suctioned,[25] or, in a vertex presentation, the body is trapped by the umbilical cord after the head has passed through the cervix.[26] In other words, surgical intervention to complete an induction is not planned. *See* Grunebaum Dep. 224:9-10 ("You plan not to do [a] D&E"). The absence of a specific intent, at the beginning of the procedure, to perform the acts prohibited by the Act takes the physician's conduct outside the scope of the Act, even in those situations in which he "anticipate[s]" that he may have to complete an induction instrumentally. Tr. 551-52 (Broekhuizen). The mere possibility that the physician may have to complete an induction or, for that matter, a D&E, in a manner that is described in the Act does not satisfy the statutory requirement that the physician perform the proscribed procedure "knowingly," much less that he or she does so "deliberately and intentionally." *See United States v. Bailey*, 444 U.S. 394, 404-05 (1980) (discussing various mental states). The Act does not apply to inductions.[27]

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[25] *See* Plaintiffs' Exh. 36 (Frederiksen Exp. Rep.), at 4 (it is only when "the induction fails" that "delivery must be completed using D&E surgical techniques"). Dr. Frederiksen normally injects potassium chloride into the fetal heart the day before an induction. *See* Frederiksen Dep. 100:6-13; 103:24-104:5; 109:8-16; 112:22-113:8 ("routinely" causes fetal death by intracardiac injection before performing an induction). The Act would not apply to Dr. Frederiksen in such situations, regardless of her intent.

[26] *See* Hammond Dep. 328:18 (not "a common scenario").

[27] Dr. Broekhuizen testified that in a few "fairly rare situations" involving lethal "disfiguring fetal anomalies," he caused fetal death (by decompressing the chest or abdomen) after the child's entire head was outside the mother's body (in procedures that began as inductions). *See* Tr. 552-53. If, at the beginning of those procedures, it was his intent to proceed in this manner, then his conduct would fall within the scope of the Act.

II.

THE ACT IS NOT UNCONSTITUTIONALLY VAGUE.

In their complaint, respondents alleged that "the [Partial-Birth Abortion Ban] Act is so vague that it fails to give physicians fair warning of which abortion procedures are prohibited." Supp. Cplt. at 2, ¶ 4. *See also id.* at 3-5, ¶¶ 9-10. For that reason, respondents contended, the Act "forces physicians to guess – under threat of criminal prosecution and civil liability – whether performing an accepted medical procedure falls within the Act's proscription." *Id.* at 10, ¶ 30. "Moreover," respondents alleged, "because of the Act's vagueness, prosecuting attorneys may differ widely as to what conduct they believe is proscribed by the Act. It thus subjects [respondents] to arbitrary and discriminatory prosecution." *Ibid.* Relying on these allegations, respondents claimed (in their Fourth Claim for Relief) that, "[b]y failing to give adequate notice of the procedures it proscribes, and by encouraging arbitrary enforcement, the Act is impermissibly vague, thereby violating the right of [respondents] and their employees and agents to due process, as guaranteed by the Fifth Amendment." *Id.* at 12, ¶ 43. As previously noted, the Ninth Circuit agreed with respondents' claim, finding that the terms "partial-birth abortion," "living fetus" and "overt act" are impermissibly vague. *See* 435 F.3d at 1181-84. That conclusion, however, is not supported by the law or the facts.

To survive a vagueness challenge, a statute "must give the person of ordinary intelligence a reasonable opportunity to know what is prohibited, so that he may act accordingly." *Grayned v. City of Rockford*, 408 U.S. 104, 108 (1972). But the Constitution does not demand "impossible standards of clarity," *Kolender v. Lawson*, 461 U.S. 352, 361 (1983) (internal quotation marks omitted), nor does it require that statutory language provide "mathematical certainty." *Grayned*, 408 U.S. at 110. Rather, a statute is not vague if it is "clear what the [statute] as a whole prohibits." *Id.*

"*Partial-Birth Abortion*"

Dr. Doe testified that the term "partial-birth abortion" has no "commonly understood meaning." Dr. Hammond agreed, adding that the Act attempts to describe a procedure that does not exist in medical practice. *See* Hammond Dep. 199:18-22.[28] But whether "partial-birth abortion" has a "commonly understood meaning" is irrelevant where, as here, the Act *itself* clearly defines the term. Respondents' expert witnesses stated or implied that the Act *would* apply to a physician who intended to perform (and did perform) an intact D&E.[29] The Act, therefore, has an irreducible core of meaning which respondents clearly understand. Their belief that the Act *could* apply to dismemberment D&Es and inductions, however, is ill-founded and, as explained above, cannot be reconciled with the language and structure of the Act.

"*Living Fetus*"

Respondents' expert medical witnesses agreed that a "living fetus" is a fetus with a heartbeat.[30] "Fetus," in turn, refers to an unborn child that has developed beyond the embryonic stage, which is ten weeks as measured by the first

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[28] Dr. Chasen, however, appeared to understand that the term "partial-birth abortion" refers to an intact D&E. *See* Tr. 1788.

[29] *See* Tr. 77-78, 92-93 (Paul); 205 (Sheehan); 282-83, 334 (Drey); 420, 422 (Doe); 507-08 (referring to "serial dilitation" method), 536-40, 582-83 (describing patients for whom intact procedure was used), 550-51 (impact of Act) (Broekhuizen); 735-37, 786 (Creinin); 795, 822-23, 830-32 (Westhoff); 1787 (Chasen); Hammond Dep. 199:7-201:7; Plaintiffs' Exh. 36 (Frederiksen Exp. Rep.), at 3-4.

[30] *See* Tr. 76 (Paul); 201 (Sheehan); 421 (Doe); 788 (Creinin); 822-23 (Westhoff); Frederiksen Dep. 105:6-11; Grunebaum Dep. 229:22-230:1; Hammond Dep. 186:13-20.

day of the woman's last menstrual period (lmp) or eight weeks post-conception. *See* Tr. 14-15, 76 (Paul); 788 (Creinin); 1710 (Chasen). The term "living fetus" does not refer to a *viable* fetus, *see* Tr. 76 (Paul); 421 (Doe); 787-88 (Creinin), *i.e.*, a fetus which has "a realistic chance of long-term survival outside the uterus." Tr. 14 (Paul). The term "living fetus" is not vague.

"*Overt Act*"

Two of respondents' experts testified, without explanation, that they did not understand what the term "overt act" means. *See* Tr. 78 (Paul); 202 (Sheehan). Numerous federal statutes, however, use the term "overt act" to define crimes,[31] and none has been held to be vague. In criminal law, "an overt act" is "an outward act done in pursuance of the crime and in manifestation of an intent or design, looking toward the accomplishment of the crime." *Chavez v. United States*, 275 F.2d 813, 817 (9th Cir. 1960). Here, "overt act" simply refers to a distinct physical act that kills the fetus after it has been partially vaginally delivered (beyond the anatomical markers set forth in the Act), "other than completion of delivery." 18 U.S.C. § 1531(b)(1)(B). Limited in scope by this language, the Act does not include those acts (*e.g.*, cutting the umbilical cord) that would be required to complete delivery. The language in the Act is not unconstitutionally vague.

III.

OFFICIAL STATE ABORTION REPORTING STATISTICS ALSO REFUTE THE VAGUENESS AND UNDUE BURDEN CHALLENGES TO THE ACT.

As explained above, the Partial-Birth Abortion Ban Act,

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[31] *See, e.g.*, 18 U.S.C. § 1117 ("overt act" in furtherance of conspiracy to commit designated homicides); *id.* § 1201(c) ("overt act" in furtherance of conspiracy to kidnap); *id.* § 2101(a) ("overt act" done to incite riot).

properly understood and interpreted, applies only to intact D&Es (performed with the requisite specific intent), and not to dismemberment D&Es and inductions. Apart from the analysis set forth in Sections I and II, however, there is a practical method for testing respondents' claims (and the Ninth Circuit's holdings) that the Act imposes an "undue burden" on physicians who perform pre-viability, second-trimester abortions, and that the Act is so vague that physicians must guess at its meaning and application.

That method examines official abortion reporting statistics from three of the five States – Indiana, Mississippi, South Carolina, South Dakota and Tennessee – whose partial-birth abortion acts were not challenged prior to this Court's decision in *Stenberg v. Carhart*, 530 U.S. 914 (2000),[32] and from one State – Virginia – whose law went into effect during litigation.[33] In considering the significance of these statistics, it must be kept in mind that the statutes in these States were not drafted with the same precision as the federal law at issue in this case.[34]

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[32] The statistics set forth in this brief, along with abortion reporting statistics from South Carolina and Tennessee, are also set forth in the brief *amicus curiae* submitted in *Gonzales v. Carhart*, No. 05-380. In *Carhart*, *amicus* presented the statistics to address an "undue burden" claim. Here, they are presented in abbreviated form to address respondents' "undue burden" and vagueness claims.

[33] Even if these statistics are not legislative facts, they are adjudicative facts of which the Court may take judicial notice. *See* FED. R. EVID. 201, and the authorities cited in the brief *amicus curiae* submitted in *Gonzales v. Carhart*, No. 05-380, at 14 note 9. Documents authenticating the statistics discussed in this brief are included in the appendices.

[34] Indiana, Mississippi and South Dakota defined "partial-birth abortion" to mean an abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery. *See* IND. CODE ANN. § 16-18-

Yet, despite the imprecise language of these statutes, physicians were not deterred from performing conventional second-trimester abortion procedures. They understood, in other words, that the partial-birth abortion statutes in these States did *not* prohibit dismemberment D&Es or inductions. And neither does the Partial-Birth Abortion Ban Act of 2003.

Indiana, Mississippi and South Dakota all enacted partial-birth abortion bans that became effective on July 1, 1997. *See* IND. CODE ANN. § 16-18-2-267.5 (West Supp. 2005) (defining offense); § 16-34-2-1(b) (West Supp. 2005) (prohibition); MISS. CODE ANN. § 41-41-71 *et seq.* (1999); S.D. CODIFIED LAWS § 34-23A-27 *et seq.* (Michie Supp. 2003). None of these statutes, prior to *Stenberg*, was construed by any state or federal court.

A comparison of official abortion reporting statistics from these States for the first half of 1997, when none of their statutes was in effect, to statistics for the second half of 1997, when all three were in effect, leaves no doubt that respondents' expressed fears that the federal Act would "chill" physicians from performing dismemberment D&Es and inductions are baseless. That comparison also shows that respondents' professed inability to understand what the Act forbids is more contrived than genuine. Review of these statistics enables this Court "to perform a reality check" on respondents' assertion that they would not be able to perform conventional second-trimester abortion procedures if the Act were allowed to go into effect. *Hope Clinic v. Ryan*, 195 F.3d 857, 870 (7th Cir. 1999) (*en banc*), *vacated and remanded with directions*, 530 U.S. 1271 (2000), *on remand*, 249 F.3d 603 (7th Cir. 2001) (*en banc*).

2-267.5 (West Supp. 2005); MISS. CODE ANN. § 41-41-73(2)(a) (1999); S.D. CODIFIED LAWS § 34-23A-32 (Michie Supp. 2003). Virginia added the phrase, "or a substantial portion thereof," to the words "living fetus." *See* VA. CODE ANN. § 18.2-74.2(D) (Michie Supp. 1999). None of these statutes required that the fetus be delivered beyond an anatomical marker *outside the mother's body*.

Indiana

The Indiana State Department of Health reported that 13,208 abortions were performed in 1997, of which 12,429 were suction curettage, 87 sharp curettage, 159 dilation and evacuation (D&E), and two intra-uterine prostaglandin instillation. *See* Appendix A-2.[35] The statistics reflect that 54.71% of the dilation and evacuation procedures (87 of 159) were performed in the second half of the year (when the Indiana partial-birth abortion act was in effect). As these statistics show, the partial-birth abortion act did not prevent physicians in Indiana from performing dismemberment D&Es.

"These data," the Seventh Circuit noted, "are incompatible with plaintiffs' *a priori* belief that the partial-birth abortion statutes will discourage the performance of the D&E procedure or cause the physician to substitute an inferior procedure." *Hope Clinic*, 195 F.3d at 871. In the eighteen months *after* the Indiana partial-birth abortion statute took effect (July 1, 1997 through December 31, 1998), there were 286 D&Es, while in the eighteen months *before* the statute took effect (January 1, 1996, through June 30, 1997), there were 263 D&Es. *See* Appendix A-2 and INDIANA TERMINATED PREGNANCY REPORT 1996 (Jan. 1998) at 20 (Table 20), INDIANA NATALITY, INDUCED TERMINATION OF PREGNANCY, AND MARRIAGE REPORT[:] STATE, COUNTY, AND CITY DATA 1998 at 84 (Table 18). This certainly does not suggest that physicians in Indiana were deterred or discouraged from performing dismemberment D&Es by the enactment of the partial-birth abortion statute.

Official abortion reporting statistics from other States confirm the Seventh Circuit's sense that "partial-birth abortion statutes need not have [and, in fact, *did* not have] the baleful effect the [respondents] foresee." *Hope Clinic*, 195 F.3d at 817.

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[35] In addition, there were 371 unknown procedures and 160 procedures not otherwise classified.

Mississippi

The Mississippi State Department of Health reported that 4,325 abortions were performed in Mississippi in 1997, of which 2,494 were suction curettage, one sharp curettage, 1,788 dilation and evacuation (D&E), and 23 intra-uterine prostaglandin instillation. *See* MISSISSIPPI VITAL STATISTICS 1997 at 43 (Table F3).[36] A breakdown of the data by procedure and month discloses that 41.94% of the dilation and evacuation procedures (750 of 1,788), and almost two-thirds of the prostaglandin instillation procedures (15 of 23) were performed in the *second* half of the year, during the time that the Mississippi partial-birth abortion act was in effect. *See* Appendix B-2. Although the number of D&Es as a percentage of all abortions declined from 44.07% for the first six months of the year (1,038 of 2,355) to 38.07% for the second six months of the year (750 of 1,970), both the number of D&Es performed in the second half of the year (750) and the number of D&Es as a percentage of all abortions for the second half of 1997 (38.07%) leave little doubt that Mississippi's partial-birth abortion act did not prevent physicians in Mississippi from performing dismemberment D&Es. Nor, given the greater numbers of induction abortions performed in the second half of the year, were Mississippi physicians deterred from performing induction procedures.

In 1998, the first full year after the Mississippi partial-birth abortion act took effect, almost one-third of all abortions performed in Mississippi (1,287 of 3,955) were D&Es. *See* MISSISSIPPI VITAL STATISTICS 1998, Table F3 at 43. This represents a slight decline from 1996, the last full year before the partial-birth abortion act took effect, when approximately 37% of all abortions (1,553 of 4,206) were D&Es. *See* MISSISSIPPI VITAL STATISTICS 1996, Table F3 at 43. Nevertheless, the small number of instillation procedures (32) and procedures not otherwise classified (13), which together account for barely one

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[36] There were 19 procedures not otherwise classified. *Id.*

percent of all abortion procedures performed in 1998, suggests that physicians performing abortions in Mississippi were not deterred from performing dismemberment D&E procedures after the partial-birth abortion act became effective. But perhaps the most significant statistic is that more than 2,000 D&Es were performed in Mississippi in the eighteen months *after* the partial-birth abortion act became effective on July 1, 1997. *See* Appendix B-2 and MISSISSIPPI VITAL STATISTICS 1998 at 43 (Table F3). Thus, there is no evidence that physicians in Mississippi were deterred from performing dismemberment D&Es by the unchallenged partial-birth abortion act.

South Dakota

The South Dakota Department of Health reported that 919 abortions were performed in South Dakota in 1997, of which 702 were suction curettage and 217 were dilation and evacuation (D&E). *See* SOUTH DAKOTA VITAL STATISTICS & HEALTH STATUS 1997 at 67-68 & 77 (Figure 24). A breakdown of the data by procedure and month reveals that 26.92% of the suction curettage procedures (189 of 702) and all but one of the dilation and evacuation procedures (216 of 217) were performed in the *second* half of the year, during which time the South Dakota partial-birth abortion act *was* in effect. *See* Appendix C-2.[37] Obviously, the South Dakota partial-birth abortion act did not prevent physicians from performing dismemberment D&Es. Remarkably, almost three times as many D&Es were performed in the eighteen months *after* the South Dakota partial-birth abortion act took effect (889 procedures) as in the eighteen months *before* the act took effect (307 procedures). *See* Appendices C-2, C-4.

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[37] That all but one of the D&Es were performed in the last four months of the year, when only 15 suction curettage procedures were performed, may have been attributable to the retirement of one abortion provider, who preferred using suction curettage, and his replacement by another, who preferred using D&Es.

Virginia

As the result of a stay of a preliminary injunction, *see Richmond Medical Center for Women v. Gilmore*, 144 F.3d 326 (4th Cir.) (Luttig, J.), the Virginia partial-birth abortion act (*see* VA. CODE ANN. § 18.2-74.2 (Michie Supp. 1999)) went into effect on July 1, 1998. The experience of physicians performing abortions in Virginia after the statute took effect completely belied the district court's statement, at the hearing on the preliminary injunction, that "the Act is written so broadly and vaguely that a prosecutor could interpret the Act to include the procedures these physicians perform such as . . . D&E, as the plaintiffs perform them." *Richmond Medical Center for Women v. Gilmore*, 11 F. Supp. 2d 795, 805 (E.D. Va. 1998). Accordingly, the plaintiffs' professed "fear [of] prosecution and the loss of their medical license to practice if they continue performing abortions in their normal course of practice," *id.*, was shown to be groundless.

The Virginia Department of Health reported that 26,115 abortions were performed in Virginia in 1998, of which 24,920 were suction curettage, 14 sharp curettage, 268 dilation and evacuation (D&E), 11 intra-uterine saline instillation and 98 intra-uterine prostaglandin instillation. *See* Appendix D-2.[38] Of these, 46.26% of the dilation and evacuation procedures (124 of 268) and approximately one-half of the instillation procedures (55 of 109) were performed in the *second* half of the year when the Virginia partial-birth abortion act *was* in effect. Dilation and evacuation procedures accounted for 1.07% of all abortions performed in the first six months (144 of 13,341) and 0.97% of all abortions performed in the last six months (124 of 12,773). Although the number of D&Es declined by 13.88% from the first half of the year to the second half of the year (144 to 124),

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[38] The Department reported three hysterectomies, two hysterotomies, 76 unknown procedures and 723 procedures not otherwise classified. *Id.*

the number of D&Es performed in the second half of the year (124) suggests, as in the case of Mississippi, that the partial-birth abortion act did not prevent physicians in Virginia from performing dismemberment D&Es. Indeed, more D&Es were performed in the last six months of 1998 (124), when the partial-birth abortion act *was* in effect, than in the last six months of 1997 (121), when the law was *not* in effect. *See* Appendices D-2, D-3. So, too, more inductions were performed in the last six months of 1998 (55), when the partial-birth abortion act *was* in effect, than in the last six months of 1997 (30), when the law was *not* in effect. *See* Appendices D-2, D-3.

* * *

To summarize the foregoing statistics, almost 1,200 D&Es were performed in just four States in the first six months *after* their partial-birth abortion acts went into effect.[39] Clearly, the physicians in those States were not deterred from performing dismemberment D&Es. Nor were they deterred from performing inductions. A total of 70 inductions were performed in Mississippi (15) and Virginia (55) in the first six months their partial-birth abortion acts were in effect, compared to 62 in the previous six months. *See* Appendices B-2, D-2. There is no evidence that physicians in these States were in any way confused as to what abortions these laws prohibited.

In evaluating the impact of the unchallenged state partial-birth abortion laws on the incidence of dismemberment D&Es and inductions, the experience of States whose laws were in effect *prior* to *Stenberg* is highly instructive. Equally instructive, however, is the experience of these States *subsequent* to *Stenberg*. *Stenberg* was decided on June 28, 2000. As of that date, none of the foregoing partial-birth abortion statutes was enforceable. Had physicians in those States whose laws had not

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[39] Dilation and evacuation: Indiana (87); Mississippi (750); South Dakota (216); Virginia (124).

been enjoined been deterred from performing dismemberment D&Es and labor inductions before the opinion in *Stenberg* was announced, one would expect a dramatic increase in the numbers of such abortions in the second half of 2000. The official abortion reporting statistics from Indiana, Mississippi and Virginia, however, do not show such an increase.[40]

In Indiana, significantly more D&Es were performed in the *first* half of 2000 (122) than in the *second* half of the year (89). *See* Appendix A-3.[41] In Mississippi, the overwhelming majority of D&Es (58 of 68, or 82.95%) were performed in the *first* half of 2000. *See* Appendix B-3. Although few intrauterine instillation procedures were reported for Mississippi in 2000, the majority of them (9 of 14) were performed in the *first* half of the year. *Id.*[42] And in Virginia, slightly more than one-half of the D&Es (1140 of 2154, or 53.57%) were performed in the *first* half of the year, as well as half (7 of 14) of the intra-uterine instillation procedures. *See* Appendix D-4.[43]

Notwithstanding respondents' claims that the Act imposes an "undue burden" on women seeking pre-viability, second-trimester abortions, and that the Act is impermissibly vague – claims that could never be empirically challenged because of

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[40] In South Dakota, the overwhelming majority of abortions performed in 2000 (840 of 878) were classified as "sharp curettage." *See* Appendix C-6. Thirteen were classified as "medical." Six of the twenty-five D&Es were performed in the first half of the year. *Id.*

[41] The data for Indiana do not separately identify the number of labor induction procedures, if any, that were performed during the year. A total of 62 unknown procedures and 147 procedures not otherwise classified were performed in Indiana during 2000.

[42] In Mississippi, only 21 procedures were not classified. *Id.*

[43] Virginia also reported 79 unknown procedures and 79 procedures not otherwise classified. *Id.*

the preliminary injunction that was entered in this case – the experience in those States whose partial-birth abortion acts *were* allowed to go into effect before *Stenberg* was decided, as well as the experience of those States after *Stenberg*, proves that physicians *did* understand the difference between what those acts did and did not prohibit. They did not prohibit – *and were not understood to prohibit* – dismemberment D&Es and labor inductions. That, in turn, suggests that respondents' expressed fears about being subjected to criminal prosecution (and civil liability) for performing dismemberment D&Es and inductions, and their professed doubts as to what conduct the Act prohibits, are unfounded and unwarranted. The Act applies *only* to a physician who, at the outset of performing an abortion, specifically intends to perform an intact D&E, partially vaginally delivers the fetus beyond the anatomical markers described in the statute for the purpose of performing an "overt act" that he or she knows will kill the fetus, and then performs the overt act that kills the fetus, other than completing delivery.

CONCLUSION

For the foregoing reasons, as well as those set forth in the brief of petitioner the United States, the judgment of the court of appeals should be reversed.

Respectfully submitted,

Thomas Brejcha
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Paul Benjamin Linton*
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Counsel of Record

August 2, 2006

[STATE SEAL]

Indiana State
Department of Health

An Equal Opportunity Employer

Mitchell E. Daniels, Jr.
Governor

Judith A. Monroe, M.D.
State Health Commissioner

March 16, 2006

Mister Paul Linton
921 Keystone Avenue
Northbrook, IL 60062

Dear Mister Linton:

I have attached the report of Indiana terminated pregnancies by month and procedure for 1997 and 2000, per your request. The data in the report are complete and accurate to the best of my knowledge. I can be reached at the address below or at 317-233-7807.

Sincerely,

/s/ Robert F. Teclaw

Robert F. Teclaw
State Epidemiologist and
Director, Epidemiology Resource Center

CERTIFIED MAIL NO. 7002 2410 0000 1837 5750

[ADDRESS OMITTED IN PRINTING]

STATE OF INDIANA _____)
) SS:
COUNTY OF *Marion* _____)

SUBSCRIBED AND SWORN TO before me, a Notary Public in and for the above state and county on this 29th day of March, 2006.

/s/ Robin R. Collins
Robin R. Collins
Notary Public

My Commission Expires
April 21, 2007

[SEAL]

County
Marion

Induced Terminations of Pregnancy by Month and Procedure
Indiana Occurrences, 1997

Month of Termination	Suction Curettage	Sharp Curettage	Dilation and Evacuation	Intra-Uterine Prostaglandin Instillation	Other	Unknown	**Total**
January	1,149	10	13	1	8	44	**1,225**
February	1,084	10	9	0	5	42	**1,150**
March	1,079	7	16	1	4	14	**1,121**
April	1,132	5	4	0	7	21	**1,169**
May	1,142	9	10	0	8	27	**1,196**
June	1,011	9	20	0	19	30	**1,089**
July	1,026	8	24	0	7	70	**1,135**
August	976	4	18	0	19	75	**1,092**
September	983	5	7	0	31	4	**1,030**
October	1,026	7	20	0	16	18	**1,087**
November	918	7	11	0	21	23	**980**
December	903	6	7	0	15	3	**934**
Total	**12,429**	**87**	**159**	**2**	**160**	**371**	**13,208**

APPENDIX B

MISSISSIPPI

[STATE SEAL]

MISSISSIPPI DEPARTMENT OF HEALTH

March 31, 2006

I, Ann L. Leach, Supervisor of the Vital Statistics Unit of the Mississippi State Department of Health, certify that the attached tables, "Induced Terminations performed in Mississippi in 1997, by Primary Procedure and Month Procedure Was Done" and "Induced Terminations Performed in Mississippi in 2000 by Primary Procedure and Month Procedure Was Done," were obtained from this office.

These Figures were obtained from the individual records "Report of Induced Termination of Pregnancy Performed in Mississippi," which are required by law to be filed with this office by the person in charge of any institution in Mississippi in which an induced termination of pregnancy is performed.

/s/ Ann L. Leach
Ann L. Leach, Supervisor
Vital Statistics

STATE OF MISSISSIPPI)
)
COUNTY OF HINDS)

SUBSCRIBED AND SWORN TO before me, a Mississippi Statewide Notary Public on this 31st day of March, 2006.

/s/ Jacqueline Bland
Jacqueline Bland
Notary Public

Mississippi Statewide Notary Public
My Commission Expires March 22, 2008
Bonded Thru Stegall Notary Service

[ADDRESS OMITTED IN PRINTING]

Induced Terminations of Pregnancy by Month and Procedure
Indiana Occurrences, 2000

Month of Termination	Suction Curettage	Sharp Curettage	Dilation and Evacuation	Other	Unknown	**Total**
January	1,074	19	17	11	19	**1,140**
February	1,106	4	31	6	13	**1,160**
March	1,035	3	22	16	4	**1,080**
April	992	1	17	4	1	**1,015**
May	996	1	19	13	5	**1,034**
June	1,125	5	16	9	6	**1,161**
July	896	1	10	21	3	**931**
August	992	0	18	9	5	**1,024**
September	899	1	16	8	0	**924**
October	976	2	18	19	3	**1, 018**
November	772	0	16	19	2	**809**
December	951	1	11	12	1	**976**
Total	**11,814**	**38**	**211**	**147**	**62**	**12,272**

Source: Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team

INDUCED TERMINATIONS PERFORMED IN MISSISSIPPI IN 1997
BY PRIMARY PROCEDURE AND MONTH PROCEDURE WAS DONE

	MONTH					
	JAN	FEB	MAR	APR	MAY	JUN
PROCEDURE	N	N	N	N	N	N
SUCTION CURRETTAGE	244	231	232	183	229	179
SHARP CURRETTAGE	0	0	0	0	1	0
DILATION & EVACUATION	165	185	177	138	193	180
INTRA-UTERINE PROSTAGLANDIN INSTALLATION	0	2	3	0	3	0
OTHER	1	4	2	0	1	2
TOTAL	410	422	414	321	427	361

B-2 (continued)

INDUCED TERMINATIONS PERFORMED IN MISSISSIPPI IN 1997
BY PRIMARY PROCEDURE AND MONTH PROCEDURE WAS DONE

	MONTH						
	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
	N	N	N	N	N	N	N
PROCEDURE							
SUCTION CURRETTAGE	222	204	188	191	185	206	2494
SHARP CURRETTAGE	0	0	0	0	0	0	1
DILATION & EVACUATION	129	196	94	136	115	80	1788
INTRA-UTERINE PROSTAGLANDIN INSTALLATION	2	0	2	5	2	4	23
OTHER	3	4	1	0	0	1	19
TOTAL	356	404	285	332	302	291	4325

INDUCED TERMINATIONS PERFORMED IN MISSISSIPPI IN 2000
BY PRIMARY PROCEDURE AND MONTH PROCEDURE WAS DONE

	MONTH					
	JAN	FEB	MAR	APR	MAY	JUN
	N	N	N	N	N	N
PRIMARY PROCEDURE						
SUCTION CURRETTAGE	289	361	394	306	296	356
DILATION & EVACUATION	55	1	1	1	0	0
INTRA-UTERINE INSTILLATION	2	1	3	1	1	1
SHARP CURRETTAGE	0	0	0	0	0	0
HYSTEROTOMY/HYSTERECTOMY	0	0	0	0	0	0
OTHER	2	1	1	0	2	4
TOTAL	348	364	399	308	299	361

INDUCED TERMINATIONS PERFORMED IN MISSISSIPPI IN 2000
BY PRIMARY PROCEDURE AND MONTH PROCEDURE WAS DONE

	MONTH						TOTAL
	JUL	AUG	SEP	OCT	NOV	DEC	
	N	N	N	N	N	N	N
PRIMARY PROCEDURE							
SUCTION CURRETTAGE	263	297	287	235	275	294	3653
DILATION & EVACUATION	0	0	1	9	0	0	68
INTRA-UTERINE INSTILLATION	0	0	2	0	1	2	14
SHARP CURRETTAGE	0	0	0	0	0	1	1
HYSTEROTOMY/HYSTERECTOMY	0	0	0	1	0	0	1
OTHER	0	2	4	3	2	0	21
TOTAL	263	299	294	248	278	297	3758

APPENDIX C
SOUTH DAKOTA

[STATE SEAL]

DIVISION OF ADMINISTRATION
600 East Capitol Avenue
Pierre, South Dakota 57501-2536
605/773-3361 FAX: 605/773-5683
www.state.sd.us/doh

Paul Benjamin Linton
Attorney at Law
921 Keystone Avenue
Northbrook, IL 60062

RE: Table entitled "Induced Abortions Occurring in South Dakota by Month of Abortion and Type of Procedure, 1997".

State of South Dakota)
County of Hughes) Department of Health

I hereby certify that the foregoing instrument is a true and correct copy of the original as the same appears on record in my office this *20* day of March, 2006

/s/ Katherine S. Mueller, Administrator, Office of Data, Statistics, and Vital Records

Subscribed and sworn to before me, this *20th* day of March, 2006.

/s/ Kathleen Zachmeier
Notary Public: South Dakota

My commission expires: *10-27-2010*

INDUCED ABORTIONS OCCURRING IN SOUTH DAKOTA BY MONTH OF ABORTION AND TYPE OF PROCEDURE, 1997

	TOTAL	TYPE PROCEDURE	
		Suction Curettage	Dilation and Evacuation (D&E)
Total	919	702	217
MONTH OF ABORTION			
January ...	74	74	0
February ..	100	99	1
March	90	90	0
April	102	102	0
May	76	76	0
June	70	70	0
July	95	95	0
August ...	79	79	0
September .	49	15	34
October ...	74	0	74
November .	54	0	54
December .	54	0	54
Not Stated .	2	2	0

Source: South Dakota Department of Health

[STATE SEAL]

DIVISION OF ADMINISTRATION
600 East Capitol Avenue
Pierre, South Dakota 57501-2536
605/773-3361 FAX: 605/773-5683
www.state.sd.us/doh

Paul Benjamin Linton
Attorney at Law
921 Keystone Avenue
Northbrook, IL 60062

RE: Table entitled "Induced Abortions Occurring in South Dakota by Type of Procedure, 1996 and 1998".

State of South Dakota) Department
County of Hughes) of Health

I hereby certify that the foregoing instrument is a true and correct copy of the original as the same appears on record in my office this 20 day of March, 2006

/s/ Katherine S. Mueller , Administrator, Office of Data, Statistics, and Vital Records

Subscribed and sworn to before me, this 20th day of March, 2006.

/s/ Kathleen Zachmeier
Notary Public: South Dakota

My commission expires: *10-27-2010*

INDUCED ABORTIONS OCCURRING IN SOUTH DAKOTA BY PROCEDURE, 1996

Total	901
PROCEDURE TYPE	
SUCTION CURETTAGE	595
DILATION & EVACUATION	306

Source: South Dakota Department of Health

INDUCED ABORTIONS OCCURRING IN SOUTH DAKOTA BY PROCEDURE, 1998

Total	674
PROCEDURE TYPE	
SUCTION CURETTAGE	1
DILATION & EVACUATION	673

Source: South Dakota Department of Health

[STATE SEAL]

DIVISION OF ADMINISTRATION
600 East Capitol Avenue
Pierre, South Dakota 57501-2536
605/773-3361 FAX: 605/773-5683
www.state.sd.us/doh

Paul Benjamin Linton
Attorney at Law
921 Keystone Avenue
Northbrook, IL 60062

RE: Table entitled "Induced Abortions Occurring in South Dakota by Month of Abortion and Type, 2000".

State of South Dakota) Department
County of Hughes) of Health

I hereby certify that the foregoing instrument is a true and correct copy of the original as the same appears on record in my office this *20* day of March, 2006

/s/ Katherine S. Mueller , Administrator, Office of Data, Statistics, and Vital Records

Subscribed and sworn to before me, this *20th* day of March, 2006.

/s/ Kathleen Zachmeier
Notary Public: South Dakota

My commission expires: *10-27-2010*

APPENDIX D

VIRGINIA

[STATE SEAL]

COMMONWEALTH OF VIRGINIA
Department of Health

CALVIN REYNOLDS
DIRECTOR

CENTER FOR HEALTH
STATISTICS
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DECLARATION OF CUSTODIAN OF PUBLIC RECORD
FEDERAL RULES OF EVIDENCE, RULE 803(8)

I, Calvin T. Reynolds, Director, Division of Health Statistics, Office of Vital Records and Health Statistics, Virginia Department of Health, Commonwealth of Virginia, hereby certify that I am custodian of the records of the Division of Health Statistics, Office of Vital Records and Health Statistics, Virginia Department of Health, a public office of the Commonwealth of Virginia, not pertaining to a court, and I do certify that the document annexed to this certificate is a true and correct copy of an original, which is on file in my office located at 1601 Willow Lawn Drive, Suite 237, Richmond, Virginia, and that the original is a record kept in that office.

Dated, and the official seal of my office affixed, this 5h day of April 2006.

/s/ Calvin T. Reynolds
Calvin T. Reynolds
Director, Division of Health Statistics
Office of Vital Records and Health Statistics
Virginia Department of Health
Commonwealth of Virginia

INDUCED ABORTIONS OCCURRING IN SOUTH DAKOTA BY MONTH OF ABORTION AND TYPE OF PROCEDURE, 2000

MONTH OF ABORTION	TYPE OF PROCEDURE			
	Total	Sharp Curettage	Dilation and Evacuation (D&E)	Medical
Total	878	840	25	13
January-June	449	438	6	5
July-December	429	402	19	8

INDUCED TERMINATIONS OF PREGNANCY OCCURRING IN VIRGINIA BY MONTH OF OCCURRENCE BY PROCEDURE TERMINATING PREGNANCY, VIRGINIA 1998

Month of Occurrence	Total	Curettage		Dilation & Evacuation	IU Instillation	
		Suction	Sharp		Saline	Prostaglandin
January	2,488	2,395	1	25	2	6
February	2,083	1,992		23		5
March	2,238	2,128	3	22		12
April	2,138	2,062		26		5
May	2,176	2,082	2	26	1	13
June	2,218	2,120	3	22	3	7
Sub-total	***13,341***	***12,779***	***9***	***144***	**6**	***48***
July	2,202	2,096	1	22		6
August	2,112	2,021	2	14	1	5
September	1,984	1,867	1	25	1	10
October	2,355	2,249	1	15	2	11
November	2,005	1,905		22		11
December	2,115	2,002		26	1	7
Sub-total	***12,773***	***12,140***	***5***	***124***	***5***	***50***
Unknown	1	1				
TOTAL	26,115	24,920	14	268	11	98

INDUCED TERMINATIONS OF PREGNANCY OCCURRING IN VIRGINIA BY MONTH OF OCCURRENCE BY PROCEDURE TERMINATING PREGNANCY, VIRGINIA 1998

Month of Occurrence	Hysterotomy	Hysterectomy	Other	Unknown
January			51	8
February			61	2
March			63	10
April			40	5
May			50	2
June			55	8
Sub-total	***0***	***0***	***320***	***35***
July	1		73	3
August	1	1	59	8
September		1	76	3
October			70	7
November			55	12
December	1		70	8
Sub-total	***3***	***2***	***403***	***41***
Unknown				
TOTAL	3	2	723	76

Month of Event by Termination Procedure Reported
Induced Terminations of Pregnancy, Virginia, 1997

Month of Occurrence	Curettage		Dilation & Evacuation	IU Instillation		Hysterotomy
	Suction	Sharp		Saline	Prostaglandin	
January	2,449	11	9	2	9	1
February	2,294	1	16	2	8	
March	2,418		16		4	
April	2,156	3	25		4	
May	2,360	2	11	1	10	
June	2,035	2	22		7	1
Sub-total	***13,712***	***19***	***99***	***5***	***42***	***2***
July	2,308	2	13		3	
August	2,184		23		4	
September	1,794		18		7	
October	1,992	1	24		7	
November	1,803	3	20	2	5	
December	1,767	4	23		2	
Sub-total	***11,848***	***10***	***121***	***2***	***28***	–
TOTAL	25,560	29	220	7	70	2

Month of Event by Termination Procedure Reported
Induced Terminations of Pregnancy, Virginia, 1997

Month of Occurrence	Hysterectomy	Other	Unknown	Total
January	1	5	3	2,489
February	1	7	4	2,334
March		11	5	2,454
April		7	3	2,198
May		8	10	2,402
June		6	9	2,082
Sub-total	***2***	***44***	***34***	***13,959***
July		2	6	2,334
August		8	4	2, 223
September		14	2	1,835
October		5	4	2,033
November		19	3	1,855
December		43	11	1,850
Sub-total	–	***91***	***30***	***12,130***
TOTAL	2	135	64	26,089

Month of Event by Termination Procedure Reported
Induced Terminations of Pregnancy, Virginia, 2000

Month of Occurrence	PROCEDURE TERMINATING PREGNANCY				
	Curettage		Dilation and Evacuation	Intra-Uterine Instillation Saline or Prostaglandin	Medical (Nonsurgical)
	Suction	Sharp			
January	2018	143	151	1	59
February	2292	138	186		71
March	2175	131	225	1	80
April	1885	110	206		68
May	1909	121	175	2	80
June	1988	115	197	3	87
Sub-total	***12267***	***758***	***1140***	***7***	***445***
July	1772	215	160	2	85
August	1736	373	182	2	99
September	1690	248	206	1	75
October	1688	125	161	2	86
November	1705	122	148		94
December	1914	106	157		70
Sub-total	***10505***	***1189***	***1014***	***7***	***509***
TOTAL	22,772	1,947	2,154	14	954

Month of Event by Termination Procedure Reported
Induced Terminations of Pregnancy, Virginia, 2000

Month of Occurrence	PROCEDURE TERMINATING PREGNANCY			
	Hysterotomy or Hysterectomy	Other	Unknown	Total
January		5	5	2,382
February		2	8	2,697
March		9	8	2,629
April		4	4	2,277
May		5	6	2,298
June		7	4	2,401
Sub-total	***0***	***32***	***35***	***14,684***
July		4	7	2,245
August		8	5	2,405
September		7	5	2,232
October		11	10	2,083
November		6	6	2,081
December		11	11	2,269
Sub-total	***0***	***47***	***44***	***13,315***
TOTAL	–	79	79	27,999

D-4 (continued)

(34)

No. 05-1382

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IN THE
Supreme Court of the United States

ALBERTO R. GONZALES, ATTORNEY GENERAL,
Petitioner,

v.

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., ET AL.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF *AMICUS CURIAE* NARAL PRO-CHOICE AMERICA FOUNDATION, ET AL., IN SUPPORT OF RESPONDENTS

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INTERESTS OF AMICI CURIAE[1]

The NARAL Pro-Choice America Foundation, NARAL Pro-Choice America and the state-based affiliates and chapter of NARAL Pro-Choice America (collectively, "NARAL Pro-Choice America") are organizations that work through the legislative process, in Congress and in the states, to secure policies that reduce unintended pregnancy and the need for abortion, while ensuring access to the full range of reproductive health services and safeguarding the constitutional right to privacy.[2] NARAL Pro-Choice America tracks state and federal legislation, writes reports and amicus briefs, educates the public, serves as a legislative consulting service, and organizes citizens and legislators to protect the freedom to choose. Our work nationally and in the states, and our annual publication Who Decides? The Status of Women's Reproductive Rights in the United States (formerly, A State-by-State Review of Abortion and Reproductive Rights), informs this brief.

SUMMARY OF ARGUMENT

The government and its *amici* appear to be using at least two strategies to eviscerate the right to abortion. First, they urge the Court to engage in judicial legislation to save an unconstitutional statute, rather than simply invalidating it, by adding a judicial gloss that plainly contravenes Congress's intent to challenge the Court's prior decisions. Second, they seek to prevent effective judicial review of unconstitutional restrictions on abortion by advocating a new, more stringent standard for challenges to statutes as unconstitutional on their

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[1] This brief was not authored, in whole or in part, by counsel for either party. No person or entity other than the *amici*, its members, and its counsel contributed monetarily to the preparation or submission of the brief. The parties consented to the filing of the brief and copies of their letters of consent have been filed with the Clerk of the Court.

[2] For a complete list of NARAL Pro-Choice American affiliates and chapter that have signed onto this brief, *see* Additional *Amici*, *infra*.

face. The Court should reject these efforts to save the Partial-Birth Abortion Ban Act of 2003, Pub. L. No. 108-105, 117 Stat. 1201 (2003) ("Partial-Birth Abortion Ban Act" or "Act"), and declare it unconstitutional and unenforceable under this Court's clear precedents.

The government is wrong to assert that if the Court finds the Act facially unconstitutional, the Court should not invalidate the entire statute, but rather should take on the role of the legislature in rewriting the Act. The Court should reject this invitation to step outside its traditional judicial role. As explained below, the constitutional flaws in the Act are fundamental and pervasive and reflect deliberate choices by Congress. Congress specifically chose not to include an exception necessary to protect the health of the woman, as required by this Court's precedents. Similarly, Congress chose to invent a nonmedical definition of so-called "partial-birth" abortion[3] that includes abortion procedures that may not be banned under the Court's decision in *Stenberg v. Carhart*, 530 U.S. 914 (2000). In light of Congress's deliberate choices, any "narrowing" construction or judicial gloss engrafting a health exception onto the Act, or rewriting its definition of the acts prohibited as a "partial-birth" abortion, would involve the Court in a legislative function well beyond its institutional adjudicative role. Such a usurpation of legislative functions would violate fundamental separation of powers principles.

There is similarly no merit to the government's suggestion, in *Gonzales v. Carhart*, No. 05-380, the companion case to this one, that *United States v. Salerno*, 481 U.S. 739 (1987), provides the default analysis for all

---

[3] "Partial-birth" abortion is a medically meaningless oxymoron. As the district court in this case noted: "The term 'partial-birth abortion' . . . is neither recognized in the medical literature nor used by physicians who routinely perform second trimester abortions." *Planned Parenthood Fed'n of Am. v. Ashcroft*, 320 F. Supp. 2d 957, 964 (N.D. Cal. 2004). The term is used here only because it is the language Congress used.

facial constitutional challenges, including facial challenges to laws restricting abortion. The government seems to have abandoned that argument in this case; *amici* agree that *Salerno* is inapplicable and need not be addressed here. Should the Court reach the issue, it should reject the government's suggestion that certain language in *Salerno* should be applied to facial challenges to laws restricting abortion. Adopting *Salerno* would overturn the well-established law of *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), and its progeny. Adopting *Salerno* would also practically preclude facial challenges to statutes restricting abortion, forcing almost all future challenges to be brought as as-applied challenges. Such a change, forcing case-by-case review, would as a practical matter preclude meaningful, effective judicial review and relief for millions of women affected by laws restricting abortion. Adopting *Salerno* as the general standard would also not only overturn well-established jurisprudence in the right to abortion context, it would also wipe away a large range of precedent in other areas of constitutional law. *Salerno* never has been, and should not become, the general rule for facial challenges.

ARGUMENT

I. THE ONLY APPROPRIATE REMEDY FOR THE MULTIPLE CONSTITUTIONAL FLAWS OF THE PARTIAL-BIRTH ABORTION BAN ACT OF 2003 IS TO INVALIDATE THE ENTIRE STATUTE.

The constitutional infirmities of the Partial-Birth Abortion Ban Act require that the entire Act be stricken as unconstitutional. The statute lacks a health exception; it is overbroad; and it is vague. Each of these flaws, standing alone, requires total invalidation. Their cumulative impact presents a particularly compelling case for full invalidation.

A. The Act's Unconstitutional Lack Of A Health Exception Requires Full Facial Invalidation.

The lack of a health exception renders the Act unconstitutional and requires complete invalidation. The Court has made it abundantly clear that the government may not restrict access to abortions that are "necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." *Roe v. Wade*, 410 U.S. 113, 164-65 (1973); *see also Casey*, 505 U.S. at 880 ("the essential holding of *Roe* forbids a State to interfere with a woman's choice to undergo an abortion procedure if continuing her pregnancy would constitute a threat to her health"). To guarantee protection against infringement of the right, "the law requires a health exception in order to validate even a post-viability abortion regulation." *Stenberg*, 530 U.S. at 930. The Court has found that a statute restricting so-called "partial-birth" abortions that lacks a health exception is unconstitutional. *See id.*

Respect for the distinct roles of the legislature and judiciary requires total invalidation of the Act based on its lack of a health exception. The Congressional Record clearly indicates that adding a health exception would contravene Congress's express legislative intent rejecting a health exception. Fashioning a "narrower" remedy by adding a health exception would not only be paradoxical, it would involve the Court in a legislative function incompatible with its judicial role. In contrast, invalidating the Act would allow Congress to decide whether to change course and amend the Act to add a health exception.

1. Any remedy narrower than invalidation would violate Congressional intent.

A narrow remedy to correct laws restricting abortion that unconstitutionally omit a health exception is permissible only where such a narrow remedy would be preferred by the

legislature to full invalidation of the statute. *Ayotte v. Planned Parenthood of N. New England*, 126 S. Ct. 961, 968 (2006). "[T]he touchstone for any decision about remedy is legislative intent, for a court cannot 'use its remedial powers to circumvent the intent of the legislature.'"[4] *Id.* (quoting *Califano v. Westcott*, 443 U.S. 76, 94 (1979) (Powell, J., concurring and dissenting in part)). When a portion of a statute is unconstitutional, the Court must inquire as to whether "the legislature [would] have preferred what is left of its statute to no statute at all." *Ayotte*, 126 S. Ct. at 968.

The statutory language and the Congressional Record make clear that Congress affirmatively and repeatedly rejected any inclusion of a health exception in the Act and would prefer no Act to one including such an exception. The Court should therefore affirm the Ninth Circuit's decision in *Planned Parenthood Federation of America, Inc. v. Gonzales*, 435 F.3d 1163 (9th Cir. 2006), striking down the Act in its entirety.

Congress indisputably was aware of the Act's constitutionally fatal lack of a health exception when it passed the Act. In *Stenberg*, the Court recognized that "a statute that altogether forbids the use of intact dilation and extraction ("D&X") creates a significant health risk" and struck down a law restricting so-called "partial-birth" abortion because the law lacked a health exception. *Stenberg*, 530 U.S. at 938. Numerous members of Congress

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[4] In *Ayotte*, the Court remanded for further exploration of legislative intent because of the sparse legislative record supporting the state statute. 126 S. Ct. at 969. Here, as the government has recognized, the Congressional Record of the Act contains abundant evidence of legislative intent. Pet'r Br. at 3 ("After years of hearings and debates, Congress passed, and the President signed, the Partial-Birth Abortion Ban Act of 2003."); Pet'r Br. at 2, *Carhart*, No. 05-380 ("Congress passed the Act after conducting nine years of hearings and debates, after carefully considering this Court's precedents, and after making extensive findings based on the substantial testimony that it had received."). Unlike in *Ayotte*, there can be no dispute as to Congress's intent in passing the Act.

issued statements highlighting the Act's constitutional infirmities. *See, e.g.*, 149 Cong. Rec. S3560, S3601 (2003) (statement of Sen. Feinstein); 149 Cong. Rec. S3560, S3576 (2003) (statement of Sen. Mikulski); 149 Cong. Rec. H4922, H4926 (2003) (statement of Rep. Nadler). Congress disregarded these warnings of constitutional infirmity and refused to incorporate a health exception in the Act.

The record makes clear not only that Congress understood the requirements announced in *Stenberg*, but also that it sought to enact a law that omitted a health exception and thereby challenged the Court's *Stenberg* ruling. Senator Santorum, the Act's lead sponsor in the Senate, stated:

> We are here because the Supreme Court defended the indefensible [in *Stenberg*] . . . . We have responded to the Supreme Court. I hope the Justices read this Record because I am talking to you . . . . [T]here is no reason for a health exception.

149 Cong. Rec. S3456, S3486 (2003) (statement of Sen. Santorum).

Congress tried to avoid the impact of *Stenberg's* holding that a health exception was required to a statute that forbade D&X by creating purported "legislative findings" that no such exception was required. Thus, Congress proclaimed that "partial-birth abortion" is "never medically necessary and should be prohibited." Partial-Birth Abortion Ban Act § 2(1). The Act also stated that no health exception was required, because:

> There exists substantial record evidence upon which Congress has reached its conclusion that a ban on partial-birth abortion is not required to contain a "health" exception, because the facts indicate that a partial-birth abortion is *never* necessary to preserve the health of a woman, poses serious risks to a woman's health, and lies outside the standard medical care.

Partial-Birth Abortion Ban Act § 2(13) (emphasis added). Congress asserted that a "moral, medical and ethical consensus" exists on this issue. *Id.* § 2(1).

But both the statutory language and the record amassed by Congress plainly undermine these assertions.[5] The Congressional Record itself indicates that there was evidence that in some cases, so-called "partial-birth" abortions were necessary to protect the health of the woman. *See, e.g., Carhart v. Ashcroft*, 331 F. Supp. 2d 805, 830 (D. Neb. 2004).

The Act itself acknowledges that a "prominent medical association" concluded that "the relative advantages and disadvantages of the procedure in specific circumstances remain unknown," and that "*there is no consensus* among obstetricians about its use." Partial-Birth Abortion Ban Act § 2(14)(C) (emphasis added).[6] Three circuit courts that have reviewed the same Congressional Record and trial evidence have found that no consensus exists that a "partial-birth" abortion is never necessary to protect the health of the woman. *Nat'l Abortion Fed'n, v. Gonzales,* 437 F.3d 278, 287 (2d Cir. 2006) ("We also conclude, on a court record and a congressional hearing record even more compelling than the record on which the Supreme Court ruled in *Stenberg*, that substantial medical opinion does support the view that the procedure might sometimes be necessary to avoid risks to the mother's health if an alternative procedure is used."); *Planned Parenthood Fed'n*, 435 F.3d at 1175-76 ("[W]e are compelled to conclude, on the basis of the record before Congress, of the congressional findings themselves, and of evidence introduced in the district court, that a substantial

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[5] Plaintiffs in this case and in *Carhart v. Ashcroft* also submitted trial evidence that the "partial-birth" abortion procedure was necessary to protect the health of the woman. *Carhart*, 331 F. Supp. 2d at 923-29; *Planned Parenthood Fed'n*, 320 F. Supp. 2d at 982-84, 987-89.

[6] The Ninth Circuit identified this medical association as the American Medical Association. *Planned Parenthood Fed'n*, 435 F.3d at 1174.

disagreement exists in the medical community regarding whether those procedures are necessary in certain circumstances [to preserve the health of women]"); *Carhart v. Gonzales*, 413 F.3d 791, 802 (8th Cir. 2005) ("If one thing is clear from the record in this case, it is that no consensus exists in the medical community.").[7]

This Court is not obligated to accept a "finding" of medical "consensus" as fact in the face of such clear contrary evidence. As then-Judge Clarence Thomas wrote for the District of Columbia Circuit in 1992:

> We know of no support . . . for the proposition that if the constitutionality of a statute depends in part on the existence of certain facts, a court may not review a legislature's judgment that the facts exist. If a legislature could make a statute constitutional simply by "finding" that black is white or freedom, slavery, judicial review would be an elaborate farce.

Lamprecht v. FCC, 958 F.2d 382, 392 n.2 (D.C. Cir. 1992). The clear lack of medical consensus places the Act squarely within the province of *Stenberg*. A health exception is constitutionally required. *Stenberg*, 530 U.S. at 937.

There can be no argument that Congress would find the Act acceptable were a health exception to be added. To the contrary, the Act's sponsors expressed the view that the Act would be devoid of meaning if it contained a health exception. Representative Chabot, the sponsor of the Act in the House, stated:

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[7] *Amici* do not believe that "medical consensus" (which Congress has failed to show even on the record it constructed) is a constitutionally relevant standard. The appropriate test remains that if there is "substantial medical authority" that banning a procedure "could" endanger a woman's health, then a health exception is required. *Stenberg*, 530 U.S. at 938.

> [A] health exception, no matter how narrowly drafted, gives the abortionist unfettered discretion in determining when a partial-birth abortion may be performed. And abortionists have demonstrated that they can justify any abortion on this ground. . . . It is unlikely, then, that a law that includes such an exception as being proposed would ban a single partial-birth abortion or any other late-term abortion.

H.R. Rep. No. 108-58, at 69 (2003); 148 Cong. Rec. H5352, H5356, H5372 (statements of Rep. Chabot); *see also* 149 Cong. Rec. S3560, S3607 (2003) (statement of Sen. Santorum); 149 Cong. Rec. S3560, S3605 (2003) (statement of Sen. DeWine); 149 Cong. Rec. H4922, H4940 (2003) (statement of Rep. Sensenbrenner).

Congress's deliberate rejection of a health exception is further demonstrated by both houses' rejection of amendments that would have added such an exception. Congress and its committees rejected amendments proposing a health exception no fewer than five times. *See* 149 Cong. Rec. S3560, S3580 (2003) (Senate rejecting a motion to commit the Act to the Judiciary Committee with instructions to consider the constitutional issues raised in *Stenberg*, including those relating to a health exception); 149 Cong. Rec. S3608, S3611 (2003) (Senate rejecting amendment that would have added a health exception, among other changes); 149 Cong. Rec. H4922, H4948 (2003) (House rejecting amendment that would have added a health exception, among other changes); 149 Cong. Rec. H4922, H4949 (2003) (House rejecting a motion to recommit the Act to the House Judiciary Committee with instructions to add a health exception); H.R. Rep. No. 108-58, at 71-73 (2003) (House Judiciary Committee rejecting an amendment that would have added a health exception to the Act). These repeated congressional rejections of health exception amendments make clear beyond doubt that Congress intended to enact a "partial-birth" abortion ban with no health exception.

In light of Congress's clear and stated intent to pass an abortion regulation without a health exception, in contravention of the requirements of *Stenberg*, any remedy short of facial invalidation of the entire Act would be inconsistent with the principle recently announced in *Ayotte*. Rewriting the Act to render it constitutional would create a remedy that is not "faithful to [the] legislative intent" of Congress, *Ayotte*, 126 S. Ct. at 969, but, rather, directly contravenes that intent.

2. Judicial rewriting of the statute to fashion a "narrow" remedy by adding a health exception would improperly engage the Court in a legislative function.

Inconsistency with congressional intent is not the only reason the Court should not cure the statutory defect by adding a health exception. Were the Court to imply such an exception, it would be performing a quintessentially legislative task. This Court repeatedly has abjured such a departure from its judicial role, declining to "save" unconstitutional legislation by judicially rewriting it.[8] *See Virginia v. Am. Booksellers Ass'n, Inc.*, 484 U.S. 383, 397 (1988) ("we will not rewrite a state law to conform it to constitutional requirements"). The Court has further

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[8] As the Chief Justice memorably expressed the concept at his confirmation hearing:

> Judges and Justices are servants of the law, not the other way around. Judges are like umpires. Umpires don't make the rules, they apply them. The role of an umpire and a judge is critical. They make sure everybody plays by the rules, but it is a limited role. . . . I will remember that it's my job to call balls and strikes, and not to pitch or bat.

Confirmation Hearing on the Nomination of John G. Roberts, Jr. to be Chief Justice of the United States Before the S. Comm. on the Judiciary, 109th Cong. 55 (2005) (statement of John G. Roberts, Jr.).

recognized that such judicial revision is inappropriate because it would involve a "serious invasion of the legislative domain." *United States v. Nat'l Treasury Employees Union*, 513 U.S. 454, 479 n.26 (1995). That is particularly true here, where Congress deliberately omitted the provisions in question.

Among the reasons that judicial statutory surgeries, such as engrafting a health exception onto the Act, are constitutionally improper is that these remedies require the Court to make policy choices that fall within the province of the legislature. In *Randall v. Sorrell*, 126 S. Ct. 2479 (2006), the Court refused to fashion a narrow remedy to the constitutional deficiencies in certain contribution limitations in the Vermont Campaign Reform Act. *Id.* at 2500 (plurality). The plurality determined that the narrow remedy of severing the unconstitutional provisions from the statute would require the Court to foresee which revisions that the Vermont legislature would choose to repair the constitutional deficiencies in the Campaign Reform Act. *Id.* Recognizing that correcting the constitutional problems in the statute would have required the Court to predict the contours of a possible legislative response, the Court in *Randall* rejected a narrow remedy. *Id.* It instead appropriately determined that the legislature was best suited to rewrite the statute to conform with constitutional requirements. *Id.* ("To sever provisions to avoid constitutional objection here would require us to write words into the statute . . ., or to leave gaping loopholes . . ., or to foresee which of many different possible ways the legislature might respond to the constitutional objections we have found.").[9]

Similarly, in *National Treasury Employees Union*, the Court refused to redraft a provision of the Ethics in Government Act when it was unsure which of several potential options Congress would have chosen to cure the

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[9] Concurring opinions did not take issue with this part of the analysis.

constitutional infirmities in the statute's honoraria ban. 513 U.S. at 479 (noting the Court's "obligation to avoid judicial legislation"). Accordingly, the Court left to Congress the quintessentially legislative task of drafting a narrower statute. *Id. See also Seminole Tribe of Fla. v. Florida*, 517 U.S. 44, 76 (1996) (stating that the Court was not at liberty to rewrite a statute using guesswork as to what choices Congress would have made to avoid the constitutional defects).

Just as in these cases, an effort to repair the constitutional defects in the Act would place the Court in the untenable position of predicting the choices Congress would make in order to enact a properly constitutional ban on so-called "partial-birth" abortion. As it did in those cases, the Court should decline any invitation to undertake this kind of legislative guesswork and should leave any redrafting of the Act and the accompanying policy choices to Congress. The only remedy consistent with our well-established system of separation of powers among the three different branches of government is total invalidation.

3. Invalidating the Act would permit Congress to determine whether it would prefer a statute with a health exception or no statute at all.

Facial invalidation of the Act would permit Congress to attempt to revise the Act to remedy its constitutional defects – or, in its discretion, to abandon the effort. Such an iterative process frequently occurs in the wake of judicial decisions invalidating federal statutes.

One modern illustration of such an appropriate iterative process between Congress and the Court involved the evolution of the Communications Decency Act ("CDA") and the Child Online Protection Act ("COPA"). In 1997, the Court struck down the certain provisions of the CDA, finding that the "indecent transmission" and "patently offensive display" provisions were overly vague and violated the free speech provisions of the First Amendment. *Reno v. ACLU*,

521 U.S. 844 (1997). Rather than defying the Court, in direct response to *Reno*, Congress enacted the COPA in order to cure the constitutional flaws in the previous law. Pub. L. No. 105-277, § 1403, 112 Stat. 2461, 2681 (1998); H.R. Rep. No. 105-775, at 5 (1998) (Commerce Committee report stating that COPA was "carefully drafted to respond to the Supreme Court's decision in *Reno v. ACLU* . . . and the Committee believes that this bill strikes the appropriate balance between preserving the First Amendment rights of adults and protecting children from harmful material on the World Wide Web.").

In 2002, the Court raised the issue of whether the COPA was overly broad or unconstitutionally vague, vacating and remanding the issues to the Third Circuit. *Ashcroft v. ACLU*, 535 U.S. 564, 564-65 (2002). Congress responded by once again amending the COPA to better conform the language of the act to the Court's decision in both *Reno* and *Ashcroft*. Pub. L. No. 108-21, § 603, 117 Stat. 650, 687 (2003). The Senate made clear that it was once again reacting to the Court's guidance. *See* 149 Cong. Rec. S5137, S5149 (2003) (statement of Sen. Grassley) ("The amendment strikes the indecency provisions, which the court ruled were unconstitutionally vague, and limits the scope of the CDA to obscenity and child pornography, which can be restricted since they do not benefit from [F]irst [A]mendment protection."). The history of the COPA and the CDA is a vivid example of a properly functioning relationship between the judiciary and the legislature.

Congress's response to the Court's decision in *United States v. Lopez*, 514 U.S. 549 (1995), offers another example. In *Lopez*, the Court invalidated the Gun-Free School Zones Act of 1990, on the grounds that Congress had failed to establish any nexus with interstate commerce sufficient to trigger its authority to regulate firearms possession and local school zones. *Id.* at 567. Congress responded by enacting a new statute that created such a nexus by adding language specifically requiring the federal government to prove that

the firearm "moved in or that otherwise affects interstate or foreign commerce." 18 U.S.C. § 922(q)(2)(A).

Yet another example is provided by the congressional response to *City of Boerne v. Flores*, 521 U.S. 507 (1997), which invalidated the Religious Freedom Restoration Act ("RFRA") as it applied to the states as an improper exercise of Congress's powers under Section 5 of the Fourteenth Amendment. 521 U.S. at 536. Congress enacted a new statute, the Religious Land Use and Institutionalized Persons Act of 2000, 42 U.S.C. § 2000cc, *et seq.* ("RLUIPA"), which narrowed the scope of RFRA protections to satisfy the *Boerne* standard. *See* 146 Cong. Rec. S7774, S7775 (2000) (remarks of Sen. Hatch) (explaining why RLUIPA conforms to *Boerne*); *see also Cutter v. Wilkinson*, 544 U.S. 709 (2005) (affirming facial validity of RLUIPA).

In contrast, where Congress has defied constitutionality rulings by the Court, the Court has continued to enforce the Constitution. For example, in *Texas v. Johnson*, 491 U.S. 397, 420 (1989), the Court held that a conviction for flag desecration under a Texas statute was inconsistent with the First Amendment and affirmed a decision of the Texas Court of Criminal Appeals that barred punishment of defendant for burning the flag as part of a public demonstration. In response, Congress passed the federal Flag Protection Act of 1989. 18 U.S.C. § 700. When the constitutionality of the statute banning flag burning was challenged, the Court did not hesitate to hold the ban unconstitutional. *United States v. Eichman*, 496 U.S. 310 (1990).

The Court should strike down the Act in its entirety and provide Congress with an opportunity, if it should choose to accept it, to draft a law that conforms to constitutional requirements.

B. The Act's Overbreadth Also Requires Facial Invalidation.

Apart from the Act's unconstitutional lack of a health exception, total invalidation of the Act also is required due to

the statute's unconstitutional overbreadth. The Act effectively outlaws abortion procedures that are completely legal and constitutionally protected. As such, the Act creates an undue burden on the exercise of the right to abortion. Under *Casey* and its progeny, such an undue burden is a basis for a complete invalidation of an abortion regulation.[10] *See, e.g., Casey*, 505 U.S. at 879; *Stenberg*, 530 U.S. at 930; *see also Roe*, 410 U.S. at 164 (striking in its entirety law restricting abortion because it "sweeps too broadly").

As explained in detail in the Ninth Circuit's opinion, the Act is overbroad because its definition of prohibited "partial-birth" abortion is imprecise and effectively criminalizes unquestionably legal forms of abortion. *Planned Parenthood Fed'n*, 435 F.3d at 1176. These flaws are identical to those of the Nebraska statute invalidated in *Stenberg* and, as in *Stenberg*, complete facial invalidation is the appropriate remedy. The Court held in *Stenberg* that an abortion ban that failed to differentiate in its statutory language between intact D&E's and non-intact D&E's constituted an undue burden, because it would prohibit most legal, pre-viability second trimester abortions and had to be facially invalidated.[11] *Stenberg*, 530 U.S. at 945.

The Act's overbreadth will have a chilling effect on both women who seek abortions and doctors who perform abortions and would face criminal sanctions if they performed even unambiguously constitutional procedures.

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[10] As confirmed in *Stenberg*, imposing an undue burden is a basis of unconstitutionality distinct from the lack of a health exception. *See Stenberg*, 530 U.S. at 930 (lack of health exception and "undue burden" of Nebraska's "partial birth abortion" ban were "independent reason[s]" the statute was unconstitutional); *see also Ayotte*, 126 S. Ct. at 965.

[11] Just as it did in omitting a health exception, Congress similarly ignored the Court's explicit guidance in *Stenberg* regarding the permissible scope of restrictions on so-called "partial-birth abortions" and problems of unconstitutional overbreadth. *See, e.g.*, 149 Cong. Rec. S3560, S3601 (2003) (statement of Sen. Feinstein); 149 Cong. Rec. H4922, H4934 (2003) (statement of Rep. Conyers).

This "chilling effect" is precisely the reason that the Supreme Court applies a form of the overbreadth doctrine in the abortion context. *See Sabri v. United States*, 541 U.S. 600, 609-10 (2004) (noting that facial challenges to statutes restricting abortion are permissible because the Court has "recognized the validity of facial attacks alleging overbreadth (though not necessarily using that term)"); *Casey*, 505 U.S. at 893-94 (invalidating law requiring spousal notice prior to abortion because women who feared their husbands' abuse were "likely to be deterred [by the provision] from procuring an abortion as surely as if the [state] had outlawed abortion in all cases"). In *Casey*, the Court found the chilling effect on women sufficient to render the statute unconstitutional on its face, even though it appeared that the majority of married women informed their husbands before obtaining an abortion. *Id.* Here, as in *Casey*, the overbreadth of the Act will deter at least some women from seeking and obtaining perfectly legal abortions.

The Act also will have a chilling effect on physicians that deters at least some of them from performing legal abortions. As summarized by the Court in *Stenberg*: "All those who perform abortion procedures using [the D&E] method must fear prosecution, conviction, and imprisonment." *Stenberg*, 530 U.S. at 945. The Court concluded that "[t]he result is an undue burden upon a woman's right to make an abortion decision." *Id.* at 946. As with the statute in *Stenberg*, the Act's overly broad language, would create an undue burden on the right to an abortion, and requiring facial invalidation.

It would be inappropriate and beyond the institutional competence of the Court to remedy the overbreadth of the Act by narrow, injunctive means. *See* Section I.A.2, *supra*. Revising the Act to incorporate constitutional limits not intended by Congress would be precisely the kind of judicial "invasion of the legislative domain" assiduously avoided by the Court. *Nat'l Treasury Employees Union*, 513 U.S. at 479 n.26. As the Ninth Circuit recognized, to cure the defects in

the statute would require that this Court "would in effect have to strike the principal substantive provision that is now in the Act and then, akin to writing legislation, adopt new terms with new definitions and new language creating limitations on the Act's scope." *Planned Parenthood Fed'n*, 435 F.3d at 1188. If Congress wants to pass a law that complies with the constitutional requirements identified by this Court and that is not unduly burdensome, it is eminently capable of doing so.

C. The Act's Unconstitutional Vagueness Further Requires Total Invalidation.

Finally, the Act is subject to facial invalidation because it is vague. A law is vague if it fails to give sufficient notice to ordinary citizens of what activity is prohibited and thus leaves open the possibility of arbitrary and discriminatory enforcement. *City of Chicago v. Morales*, 527 U.S. 41, 60, 64 (1999). The Court demands a higher level of clarity from criminal statutes such as the Act which might infringe upon constitutionally protected activity. *Reno*, 521 U.S. at 871-72. Abortion is a constitutionally protected right and, accordingly, the Act is subject to heightened vagueness review. *Colautti v. Franklin*, 439 U.S. 379, 394 (1979) (invalidating abortion statute because it "conditions potential criminal liability on confusing and ambiguous criteria," and "therefore presents serious problems of notice, discriminatory application, and chilling effect on the exercise of constitutional rights"), *overruled in part on other grounds*, *Webster v. Reproductive Health Servs.*, 492 U.S. 490 (1989).

As noted by the Ninth Circuit, the Act is unconstitutionally vague. For the same reasons that the Act is overly broad, the Act does not clearly warn medical practitioners subject to the Act what kind of procedures are prohibited. *Planned Parenthood Fed'n*, 435 F.3d at 1332. Several of its statutory terms are undefined and susceptible of several meanings. *Id.* at 1333.

Physicians performing abortions are likely to be chilled by the Act's vagueness. As the district court found, because "Congress did not spell out those procedures which were *not* covered by the law," there are serious ambiguities about whether the statutory prohibition includes commonly used previability procedures such as D&E. *Carhart*, 331 F. Supp. 2d at 1037-40.[12] Tellingly, this Court found the Nebraska statute in *Stenberg* facially invalid for similar reasons. *See Stenberg*, 530 U.S. at 939. Congress's refusal to heed *Stenberg's* requirement for clarity regarding procedures covered by the Act makes it impossible, as the district court correctly found, for physicians to "distinguish between that which is criminal and that which is lawful." *Carhart*, 331 F. Supp. 2d at 1040. The Act therefore renders doctors "subject to prosecution for a federal felony when they had no intention of performing the banned procedure, but the exigencies of the situation forced upon them the necessity of doing something that looked similar to the banned procedure." *Id.* at 1132. *See also Planned Parenthood of Wisconsin v. Doyle*, 162 F.3d 463, 469 (7th Cir. 1998) ("When vague statutes prescribe heavy penalties for violation, rational people avoid any conduct that *might* be thought to fall within the statute's scope, even if in an error free litigation the conduct would be sure to be found constitutionally protected.").

The government's "specific intent" limiting construction – that the specific intent necessary to commit the crime must be formulated before the procedure begins *see* Pet'r Br. at 32-33 – does not cure this fatal vagueness problem. Such a construction will not mitigate the chilling effect on doctors. Doctors who are required to make a

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[12] The Congressional Record includes warnings about the vagueness of the Act. 149 Cong. Rec. H4922, H4933 (2003) (statement of Rep. Farr); *id.* at H4934 (statement of Rep. Conyers); 149 Cong. Rec. S3608, S3611-12 (2003) (statement of Sen. Feingold); 149 Cong. Rec. S3560, S3600 (2003) (statement of Sen. Feinstein).

medical decision at the time a woman seeks medical treatment will still run the risk of being criminally charged. That a "specific intent" construction may ultimately make it easier to defend would not affect the possibility of being charged in the first place.

And, in any case, the argument has no merit. Such a construction finds no support in the plain text of the statute and would require this Court to rewrite the statute to include language Congress chose not to include. *See Stenberg*, 530 U.S. at 940-45 (noting that it is not the role of the Court to rewrite a statute and construct limitations that the words of the statute will not reasonably support); *Reno*, 521 U.S. at 884 (narrowing conditions only permissible where statute is "readily susceptible" to such conditions). *See also Am. Booksellers*, 484 U.S. at 397 (same).

Because of the Act's vagueness, it should be invalidated. *See Morales*, 527 U.S. at 64; *Kolender v. Lawson*, 461 U.S. 352, 358 (1983); *Colautti*, 439 U.S. at 394 (affirming facial invalidation of provision of Pennsylvania Abortion Control Act due to vagueness of statutory viability determination); *Papachristou v. City of Jacksonville*, 405 U.S. 156, 171 (1972).

II. THE LANGUAGE OF *UNITED STATES v. SALERNO* IS NOT A GENERAL RULE FOR ALL FACIAL CHALLENGES AND SHOULD NOT BE APPLIED IN THIS CASE.

In the companion case of *Gonzales v. Carhart*, the government asserts that "the standard for facial challenges" is that set forth in *United States v. Salerno*, 481 U.S. 739 (1987), and urges the Court to hold that the *Salerno* language, not the test required by *Casey*, applies to facial constitutional challenges to statutes restricting abortion. Cert. Pet. at 18-21, *Carhart*, No. 05-380. Certain states also advocate this position. *See* Amicus Br. of the States of Texas et al. at 19, *Carhart*, No. 05-380.

Salerno involved a facial constitutional challenge to provisions of the Bail Reform Act. Justice Rehnquist, writing for the majority, stated:

> A facial challenge to a legislative Act is, of course, the most difficult challenge to mount successfully, since the challenger must establish that no set of circumstances exists under which the Act would be valid. The fact that the [Act] might operate unconstitutionally under some conceivable set of circumstances is insufficient to render it wholly invalid, since we have not recognized an "overbreadth" doctrine outside the limited context of the First Amendment.

Salerno, 481 U.S. at 745.

Despite the government's assertion in *Carhart*, this *Salerno* language is not – and never has been – the generally applicable standard for facial challenges. Rather, as Justice Stevens wrote for a plurality in *Morales*, "[t]o the extent we have consistently articulated a clear standard for facial challenges, it is *not* the *Salerno* formulation, which has *never* been the decisive factor in any decision of this Court, including *Salerno* itself." *Id.* at 55 n.22 (Stevens, J., Ginsburg, Souter, JJ. concurring) (emphasis added).[13] *See also Janklow v. Planned Parenthood, Sioux Falls Clinic*, 517

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[13] A careful review of *Salerno* makes clear that the result in that case did not turn on application of the "no set of circumstances" language but, rather, on the Court's conclusion that the Bail Reform Act did not facially violate constitutional norms. *See Salerno*, 481 U.S. at 746 (act does not violate substantive due process because the pretrial detention it authorizes is regulatory, not penal, and is justified by a compelling governmental interest in preventing crime by arrestees); *id.* at 751-52 (Act's procedures, including enumerated criteria, a judicial hearing, a clear and convincing evidence standard, a requirement of written findings of fact, and immediate appellate review, provided "extensive safeguards" sufficient to satisfy the Due Process Clause); *id.* at 752-53 (Act does not violate excessive bail clause of Eighth Amendment).

U.S. 1174, 1175-76 (1996) (mem.) (Stevens, J., denying certiorari) ("[T]he dicta in *Salerno* does not accurately characterize the standard for deciding facial challenges, and neither accurately reflects the Court's practice with respect to facial challenges, nor is it consistent with a wide array of legal principles.") (internal quotation marks and citation omitted).

Applying the standard favored by the government in *Carhart* would dangerously limit constitutional protections, allowing statutes that are unconstitutional in all but one circumstance to remain in effect. It would overturn this Court's well-established law governing facial constitutional challenges under the Free Speech and Free Exercise Clauses and the Due Process Clause. Adopting the *Salerno* language as the rule in all contexts would also sweep away well-established law governing facial constitutional challenges to laws restricting abortion.

Perhaps recognizing that its stance in *Carhart* is radical and unsupportable, the government appears to have retreated from that position. Pet'r Br. at 16, 18 & n.2 (arguing that the Act is constitutional under the *Casey* test and, therefore, the case is not an "appropriate vehicle" to determine whether the *Salerno* language or the *Casey* standard applies to facial challenges to statutes restricting abortion). *See Casey*, 505 U.S. at 895. But the government has not expressly repudiated its position in *Carhart*.

The Court should refuse to adopt the *Salerno* language in this case or its companion case. To do so would establish *Salerno* as the general rule, sweeping away existing precedent, both within and outside the abortion context.

A. The *Salerno* Language Does Not Apply To First Amendment Facial Challenges To Statutes On Grounds Of Overbreadth.

As acknowledged in *Salerno* itself, when a plaintiff challenges a statute on First Amendment overbreadth grounds, the possibility of constitutional application in

certain factual circumstances does not preclude a facial challenge and invalidation of the statute. *See Salerno*, 481 U.S. at 745. Facial invalidation of an overbroad law ensures that the "threat of enforcement" of the law does not chill protected speech. *Reno,* 21 U.S. at 872 (stating "[t]he severity of criminal sanctions may well cause speakers to remain silent rather than communicate even arguably unlawful words, ideas, and images"). *See also Ashcroft v. Free Speech Coal.*, 535 U.S. 234, 244 (2002) ("The Constitution gives significant protection from overbroad laws that chill speech within the First Amendment's vast and privileged sphere.").

The Court's decisions after *Salerno* confirm that facial constitutional challenges on grounds of overbreadth in violation of the First Amendment may result in invalidation of the challenged statutory provision even if it could be applied constitutionally in some factual circumstances. *See Free Speech Coal.*, 535 U.S. at 255 (holding some provisions of the Child Pornography Protection Act unconstitutionally overbroad because the statute "bann[ed] unprotected speech" as well as "prohibited or chilled" "a substantial amount of protected speech"); *Reno*, 521 U.S. at 882 (holding the statute unconstitutionally overbroad because it "effectively suppresses a large amount of speech that adults have a constitutional right to receive and to address to one another").

B. *Salerno* Is Not Applied To Facial Constitutional Challenges On Grounds Of Vagueness.

Like overbreadth, the vagueness doctrine seeks to prevent potential chilling effects that will deter individuals from exercising their constitutional rights. Applying the *Salerno* language to preclude facial challenges to unconstitutionally vague laws would undermine the protection against this chilling effect afforded by the vagueness doctrine because it would sweep away the standard that a vague law may be invalidated as

unconstitutional "even when it could conceivably have had some valid application." *Kolender*, 461 U.S. at 358 n.8.

In *Morales*, for example, the Court held unconstitutional a vague loitering law, 527 U.S. at 60, but expressly refused to apply *Salerno* as advocated by the dissenters. *See id.* at 77-78 (Scalia, J., dissenting). A majority agreed that the law should be invalidated because "the ordinance does reach a substantial amount of innocent conduct." *Id.* at 60. Because not all of the conduct reached by the statute was innocent, application of the *Salerno dicta* would have protected the statute from facial invalidation.

Three Justices favored an analysis even more at odds with *Salerno*. They concluded that "even if an enactment *does not reach a substantial amount* of constitutionally protected conduct, it may be impermissibly vague because it fails to establish standards . . . sufficient to guard against the arbitrary deprivation of liberty interests." *Id.* at 52 (Stevens, J., Ginsburg, Souter, JJ., concurring) (emphasis added).

C. The *Salerno* Language Is Not Applied To Establishment Clause Challenges.

The Court also has declined to apply *Salerno* in Establishment Clause cases, despite the fact that "[n]o speech will be 'chilled' by the existence of a government policy that might unconstitutionally endorse religion over nonreligion." *Santa Fe Indep. Sch. Dist. v. Doe*, 530 U.S. 290, 318 (2000) (Rehnquist, CJ, dissenting). For example, in *Bowen v. Kendrick*, 487 U.S. 589 (1988), taxpayers brought an Establishment Clause challenge against a law that authorized federal grants to organizations providing services related to premarital adolescent sexual relations and pregnancy. Applying the three-part analysis set forth in *Lemon v. Kurtzman*, 403 U.S. 602 (1971), rather than *Salerno*, the Court held that the Act did not, on its face, violate the Establishment Clause. *See Bowen*, 487 U.S. at 598. In his dissent, Justice Blackmun thought it was "worth acknowledging explicitly" that he agreed with the majority's

refusal to use *Salerno* in Establishment Clause cases. *Id.* at 627 n.1 (Blackmun, J., dissenting). He observed that applying *Salerno* would be "wholly incongruous with analysis of an Establishment Clause challenge under *Lemon*," "would render review under the Establishment Clause a nullity," and would be an "artifice" that would "eviscerate[]" the Establishment Clause. *Id.*

Santa Fe Independent School District involved another Establishment Clause facial challenge, to a policy allowing prayers before football games. 530 U.S. at 314. The majority struck down the policy as facially invalid under *Lemon*. *Id.* The Court again refused to apply *Salerno*, despite the dissent's position that exceptions to *Salerno* should be recognized only in overbreadth cases and not in Establishment Clause cases. *Id.* at 318 (Rehnquist, CJ., dissenting). *See also Ingebretsen v. Jackson Pub. Sch. Dist.*, 864 F. Supp. 1473, 1483 (S.D. Miss. 1994) ("the rigid dictates of *Salerno* do not apply in Establishment Clause cases. The Court has stated that facial challenges to laws impacting the Establishment Clause are best analyzed under the *Lemon* test.") (citing *Bowen*, 487 U.S. at 601-02).

D. *Salerno* Also Is Not Applied To Other Types Of Facial Challenges Outside the First Amendment Context.

Other exceptions to *Salerno* have no necessary relation to the First Amendment or overbreadth. Decisions that do not employ *Salerno* in evaluating other types of constitutional challenges further demonstrate that *Salerno* is not the general rule.

1. Due Process Or Equal Protection

The *Salerno* language has not been applied in substantive due process cases. In addition to cases challenging laws restricting abortion, *see* Section II.E, *infra*, in *Romer v. Evans*, 517 U.S. 620 (1996), the Court held unconstitutional an amendment to Colorado's state constitution that would have prohibited any state or local

government action that would have protected homosexuals against discrimination. *Id.* at 623. Justice Scalia dissented arguing that this holding was inconsistent with *Salerno* because there were some circumstances under which the amendment could have been constitutionally applied; at the time (prior to *Lawrence v. Texas*, 539 U.S. 558 (2003)), it was permissible to criminalize sodomy. *Id.* at 642-43 (Scalia, J., dissenting).

The Court also declined to rely on *Salerno* in *Washington v. Glucksberg*, 521 U.S. 702 (1997). Respondents argued that a statute banning assisted suicide was facially invalid under the Due Process clause because it violated Fourteenth Amendment liberty interests. *Id.* at 707-08. Although the Court reversed the lower courts' decisions that the statute was unconstitutional, *id.* at 705-06, the majority opinion did not question "[t]he District Court determin[ation] that *Casey*'s 'undue burden' standard, not the standard from *United States v. Salerno* (requiring a showing that 'no set of circumstances exists under which the [law] would be valid'), governed the plaintiffs' facial challenge to the assisted-suicide ban." *Id.* at 708 n.5 (citation omitted). Moreover, Justice Stevens, concurring, stated that "[t]he appropriate standard to be applied in cases making facial challenges to state statutes has been the subject of debate within this Court," and he stated that he "believe[d] the Court has [n]ever actually applied such a strict standard, even in

Salerno itself, and the Court does not appear to apply *Salerno* here."[14] *Id.* at 739-40 (Stevens, J., concurring).

2. Foreign Commerce Clause

The Court also declined to apply *Salerno* in determining whether an Iowa tax scheme that taxed dividends received from foreign, but not domestic, subsidiaries violated the Foreign Commerce Clause. *Kraft Gen. Foods, Inc. v. Iowa Dep't of Revenue & Fin.*, 505 U.S. 71, 72-73 (1992). Over the dissent's objection that *Salerno* should have been applied, *id.* at 82-83, the Court concluded that the statute facially discriminated against foreign commerce and therefore violated the Foreign Commerce Clause. *Id.* at 82; *see also Caterpillar, Inc. v. Comm'r of Revenue*, 568 N.W.2d 695, 700 n.8 (Minn. 1997).

3. Enforcement Of The Fourteenth Amendment

Finally, *Salerno* is in tension with a line of cases analyzing constitutional challenges to statutes passed by Congress, pursuant to Section 5 of the Fourteenth Amendment, to protect citizens against potential unconstitutional state action. The Court has held the statutes unconstitutional even where some of the conduct they

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[14] *Reno v. Flores*, 507 U.S. 292 (1993), which cited *Salerno* in its due process analysis, is not to the contrary. In *Flores*, the Court rejected the substantive due process claim, finding that the case involved no "fundamental rights." *Id.* at 305. Nor was the *Salerno* language necessary to the due process holding because far from there being no set of circumstances in which the statute was *constitutional* as required by *Salerno*, the Court expressed skepticism that there would be very many circumstances - if any - in which it would be *unconstitutional*. *Id.* at 309. *See also Caplin & Drysdale v. United States*, 491 U.S. 617, 634 (1989) (*Salerno* cited in rejection of as-applied challenge to forfeiture statute noting that defendant made no direct allegation of prosecutorial abuse and unconstitutionality "under some conceivable set of circumstances" is not a sufficient showing). Neither case has been subsequently cited as supporting the application of the *Salerno* language.

prohibited was unconstitutional and therefore within Congress's power to prohibit. For example, in *City of Boerne*, *supra*, the Court facially invalidated the Religious Freedom Restoration Act ("RFRA"). 521 U.S. at 511. RFRA was supposed to ensure that state laws did not infringe the Establishment Clause. *See id.* at 515-16. Applying the *Salerno* language, the Court would have had to find that there could have been no constitutional application of the statute. *Salerno*, 481 U.S. at 745. Instead, the Court invalidated RFRA because it was inappropriate "[i]n most cases." *City of Boerne*, 521 U.S. at 535. The Court articulated a far a less stringent standard than *Salerno*: "Preventive measures prohibiting certain types of laws may be appropriate when there is reason to believe that *many of the laws* affected by the congressional enactment have a *significant likelihood* of being unconstitutional." *Id.* at 532 (emphasis added). *See also Kimel v. Fla. Bd. of Regents*, 528 U.S. 62, 88 (2000) (failing to apply *Salerno* in striking down a law that prohibited states from using age as a discriminating factor because the law "prohibits very little conduct likely to be held unconstitutional"); *Fla. Prepaid Postsecondary Educ. Expense Bd. v. College Sav. Bank*, 527 U.S. 627 (1999) (striking down the Patent Remedy Act even though it would have remedied some state constitutional violations).

E. The Salerno Language Is Not, And Should Not Be, Applied To Facial Constitutional Challenges To Laws Restricting Abortion.

Consistent with the Court's refusal to apply *Salerno* to cases involving fundamental due process rights, and vague or overbroad laws, the Court similarly has declined to apply the "no set of circumstances" language to laws restricting abortion. Indeed in *Casey* the Court made clear that a statute that unduly burdens the right of privacy inherent in a woman's right to choose is subject to facial invalidation without application of *Salerno*. *See, e.g., Stenberg*, 530 U.S. at 930; *Casey*, 505 U.S. at 895 (facially invalidating statutory

provision that unduly burdened a woman's right to an abortion without applying *Salerno*).

In *Stenberg*, the Court built upon its nearly decade-old decision in *Casey* when it held that a Nebraska statute criminalizing so-called "partial-birth" abortions violated a woman's right to privacy.[15] 530 U.S. at 921. As in *Casey*, *Salerno* was not a factor in *Stenberg*, nor was it even mentioned in passing. Instead, the Court upheld a facial challenge to a Nebraska abortion statute under the *Casey* undue burden standard. In particular, the Court found that the statute: (1) lacked a "health exception" for circumstances where the abortion would be necessary to preserve the health of the woman and (2) imposed an undue burden on a woman's ability to make an abortion decision where doctors feared prosecution, conviction, and imprisonment. *Id.* at 945-46. Rejecting Nebraska's claim that a health exception was not necessary, the Court found that *Casey* requires a health exception when an abortion procedure is necessary to the preserve the life or health of the woman. *Id.* at 938 (stating that health exception was "no departure from *Casey*, but simply a straightforward application of its holding"); *see also Ayotte*, 126 S. Ct. at 965-66 (vacating and remanding on remedy alone, without disputing the First Circuit's reliance on the "undue burden" standard in holding unconstitutional a statute restricting abortion).

All but one of the Circuits that have considered this question agree that *Casey* and *Stenberg*, not the *Salerno*

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[15] The right to abortion is rooted in privacy rights emanating from, *inter alia*, the First, Fifth and Fourteenth Amendments. *See Griswold v. Connecticut*, 381 U.S. 479, 484 (1965) ("[S]pecific guarantees in the Bill of Rights have penumbras, formed by emanations from those guarantees that help give them life and substance. . . .Various guarantees create zones of privacy.") (citation omitted); *Roe*, 410 U.S. at 129, 152-53 (relying in part on *Griswold* to find that the right to an abortion is a privacy right based on various constitutional amendments). As noted above, the Court repeatedly has declined to apply *Salerno* to challenges arising under the First Amendment and the Due Process clause.

language, provide the appropriate standard for determining the facial constitutionality of a statute restricting abortion. *Planned Parenthood of Idaho, Inc. v. Wasden*, 376 F.3d 908, 920 n.9 (9th Cir. 2004) (noting that "[a] majority of the circuits now agree that *Casey* effectively precludes the application of *Salerno* in abortion cases"); *Nat'l Abortion Fed'n*, 437 F.3d at 294 ("at least 'seven circuits have concluded that *Salerno* does not govern facial challenges to abortion regulations'") (Walker, J., concurring) (citation omitted); *see also Carhart*, 413 F.3d at 794-95 (refusing to apply *Salerno*); *Planned Parenthood of the Rocky Mountains Servs., Corp. v. Owens*, 287 F.3d 910 (10th Cir. 2002) (reviewing constitutionality of abortion statute under *Stenberg* without considering *Salerno* language); *Planned Parenthood of Cent. N.J. v. Farmer*, 220 F.3d 127, 142 (3d Cir. 2000) ("several courts, including our own, have noted [that] the *Casey* Court muted the *Salerno* requirement in the abortion context"). And even the outlying Fifth Circuit has had conflicting holdings. *Compare Barnes v. Moore*, 970 F.2d 12, 14 n.2 (5th Cir. 1992) (holding *Casey* did not overrule *Salerno*) *to Sojourner T v. Edwards*, 974 F.2d 27 (5th Cir. 1992) (striking down a statute under *Casey*, although it would arguably be valid under *Salerno*).

Wholly apart from the binding long-established precedent of *Casey* and *Stenberg*, *Salerno* does not apply because the Act falls into *Salerno's* overbreadth exception. Although in *Salerno* the Court articulated an exception only for First Amendment overbreadth challenges, since then the Court has "recognized the validity of facial attacks alleging overbreadth" in the abortion context. *See Sabri*, 541 U.S. at 609-10 (citation omitted).

F. All Of These Examples Illustrate That *Salerno* Is Not The General Rule.

Thus, the Court has declined to apply the *Salerno* language to a variety of facial constitutional challenges. Were the Court to determine that *Salerno* should now be the

default standard for facial challenges, including facial challenges regarding the constitutionality of laws restricting abortion, it would effectively overrule numerous decisions involving a wide variety of constitutional challenges. We urge the Court to decline the invitation to engage in such a wholesale revision of constitutional litigation standards. Were the Court to do so, it would effectively insulate from challenge laws with broad unconstitutional impact only because, in at least one conceivable circumstance, they might not have such an impact.

CONCLUSION

In adopting the Partial-Birth Abortion Ban Act, Congress threw down the gauntlet to the Court by enacting a ban on abortions that does not comply with the constitutional requirements articulated by the Court in *Casey* and *Stenberg*. Having done so, Congress necessarily assumed the risk of the consequences of its decision: a judicial declaration that, on its face, the Act is unconstitutional. *Amici* respectfully submit that, in these circumstances, the only appropriate course is for the Court to reaffirm its prior precedent and issue such a declaration.

Respectfully submitted,

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In The

Supreme Court of the United States

ALBERTO R. GONZALES,

Petitioner,

v.

PLANNED PARENTHOOD FEDERATION OF AMERICA, *et al.*,

Respondents.

ON *WRIT OF CERTIORARI* TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF *AMICUS CURIAE* OF THE NATIONAL LEGAL FOUNDATION,

in support of the *Petitioner*

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Unborn Victims of Violence Act, 18 U.S.C. § 1841 (2004) 1, 2, 4, 6, 9, 10

INTEREST OF AMICUS CURIAE[1]

The National Legal Foundation (NLF) is a 501c(3) non-profit corporation organized to defend, restore, and preserve constitutional liberties, family rights, and other inalienable freedoms. The NLF and its donors and supporters are vitally concerned with the outcome of this case because of its public interest litigation and educational activities relating to the issue of abortion.

SUMMARY OF THE ARGUMENT

There is a long history of both Congress and various state legislatures recognizing the need to protect the life of unborn children. This has been expressed by both the Unborn Victims of Violence Act and various state fetal homicide laws. While these laws have been challenged as unconstitutional multiple times, they have consistently been upheld by the courts.

The Partial Birth Abortion Ban Act is the natural and logical extension of the Unborn Victims of Violence Act. It would be inconsistent to uphold statutes recognizing the fundamental right to life of unborn children and then strike down a ban on a form of abortion which grotesquely violates this right.

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[1] The parties have consented to the filing of this brief. Copies of the letter of consent accompany this brief. No counsel for any party has authored this brief in whole or in part. No person or entity has made any monetary contribution to the preparation or submission of this brief, other than the *Amicus Curiae*, its members, and its counsel.

ARGUMENT

I. THIS COURT SHOULD UPHOLD THE PARTIAL BIRTH ABORTION BAN ACT BECAUSE IT IS THE LOGICAL EXTENSION OF THE UNBORN VICTIMS OF VIOLENCE ACT

On April 1, 2004, Congress enacted the Unborn Victims of Violence Act, 18 U.S.C. § 1841 (LEXIS through Pub. Law 109-245)[2], which officially recognized the fact that

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2 The Unborn Victims of Violence Act reads as follows:

(a) (1) Whoever engages in conduct that violates any of the provisions of law listed in subsection (b) and thereby causes the death of, or bodily injury (as defined in section 1365) to, a child, who is in utero at the time the conduct takes place, is guilty of a separate offense under this section.

(2) (A) Except as otherwise provided in this paragraph, the punishment for that separate offense is the same as the punishment provided under Federal law for that conduct had that injury or death occurred to the unborn child's mother.

(B) An offense under this section does not require proof that--

(i) the person engaging in the conduct had knowledge or should have had knowledge that the victim of the underlying offense was pregnant; or

(ii) the defendant intended to cause the death of, or bodily injury to, the unborn child.

(C) If the person engaging in the conduct thereby intentionally kills or attempts to kill the unborn child, that person shall instead of being punished under subparagraph (A), be punished as provided under sections 1111, 1112, and 1113 of this title for intentionally killing or attempting to kill a human being.

(D) Notwithstanding any other provision of law, the death penalty shall not be imposed for an offense under this section.

(b) The provisions referred to in subsection (a) are the

unborn children may be separate victims of violence. As will be demonstrated below, a sizable majority of states either preceded or followed Congress in recognizing unborn children as potential victims of violence, and when such legislation has been challenged, courts have consistently upheld these laws. It would then be illogical for the courts to recognize the fact that unborn children have a distinct right to life as a separate identity inside the womb and, therefore, to be protected from violence; but then to refuse to uphold a ban on such a gruesome practice as partial-birth abortion. This Court is well aware of the violence committed against the unborn child during a partial birth abortion, having itself described it as follows:

> Like other versions of the D&E technique, it begins with induced dilation of the cervix. The procedure then involves removing the fetus from the uterus through the cervix "intact," i.e., in one pass, rather than in several passes. It is used after 16 weeks at the earliest, as vacuum aspiration becomes ineffective and the fetal skull becomes too large to pass through the cervix. The intact D&E proceeds in one of two ways, depending on the presentation of the

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following: [list of section numbers omitted]
(c) Nothing in this section shall be construed to permit the prosecution--
(1) of any person for conduct relating to an abortion for which the consent of the pregnant woman, or a person authorized by law to act on her behalf, has been obtained or for which such consent is implied by law;
(2) of any person for any medical treatment of the pregnant woman or her unborn child; or
(3) of any woman with respect to her unborn child.
(d) As used in this section, the term "unborn child" means a child in utero, and the term "child in utero" or "child, who is in utero" means a member of the species homo sapiens, at any stage of development, who is carried in the womb.

> fetus. If the fetus presents head first (a vertex presentation), the doctor collapses the skull; and the doctor then extracts the entire fetus through the cervix. If the fetus presents feet first (a breech presentation), the doctor pulls the fetal body through the cervix, collapses the skull, and extracts the fetus through the cervix.

Stenberg v. Carhart, 530 U.S. 914, 927 (U.S. 2000).

The illogic is highlighted by the fact that children fully within the womb would receive more protection from violence that those children who have been partially delivered.

In addition to the protection offered by the Unborn Victims of Violence Act, mentioned above, thirty-five states have enacted laws recognizing that unborn children may be considered victims.[3] State Homicide Laws That Recognize

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[3] Although comments will follow on several of the states, a complete list is also instructive. Massachusetts provides protection through judicial interpretation of its laws. *Commonwealth v. Lawrence*, 536 N.E.2d 571 (Mass. 1989); *Commonwealth v. Cass*, 467 N.E.2d 1324 (Mass. 1984). Thirty-four additional states provide protection by statute and one does so by judicial interpretation of a statute. They are as follows: 2006 Ala. Laws Act 2006-419 (H.B. 19); 2006 Alaska Sess. Laws Ch. 73; Ariz. Rev. Stat. Ann. §§ 13-1102 to -1105 (LEXIS through 2005 legislation); Ark. Code Ann. §§ 5-1-102(13)(B), 5-10-101 to -105 (LEXIS through 2006 First Extraordinary Sess.); Cal. Penal Code § 187 (LEXIS through 2006 legislation); Fla. Stat. §§ 316.193, 782.071 to -.09 (LEXIS through 2006 Reg. Sess.); Ga. Code Ann. §§ 16-5-20, -28, -29, 80 (LEXIS through 2006 Reg. Sess.); Idaho Code Ann. § 18-4001 (LEXIS through 2006 Reg. Sess.); 720 Ill. Comp. Stat. 5/9-1.2, -2.1, -3.2, 5/12-3.1, -4.4 (LEXIS through Pub. Act 94-942); Ind. Code. Ann. §§ 35-42-1-1, -3, -4 (LEXIS through 2005 Reg. Sess.); Ky. Rev. Stat. Ann. §§ 507A.010-.060 (LEXIS through 2005 Reg. Sess.); La. Rev. Stat. Ann. §§ 14:32.5 – 8 (LEXIS through 2006 First Extraordinary Sess); Md. Code Ann., Crim. Law § 2-103 (LEXIS through 2005 Reg. Sess.); Mich. Comp. Laws §§ 750.90(a)-(f) (LEXIS through Pub. Act 214); Minn. Stat. §§ 609.21, -.266, -.2661 to -.2665, -.268(1) (LEXIS through 2005 legislation); Miss. Code Ann. § 97-3-37 (LEXIS through 2005 Reg. Sess.); Mo. Rev. Stat.

Unborn Victims, http://www.nrlc.org/Unborn_Victims /Statehomicidelaws092302.html (June 16, 2006). Missouri, for example, has declared that unborn children have their own human identity separate from their mothers and that they deserve the full protection the law has to offer. Mo. Rev. Stat. § 1-205 (LEXIS through 2005 legislation). Other states, such as Indiana, Massachusetts, and Alabama, have explicitly incorporated unborn children into their already existing violent crime statutes through legislative action or judicial interpretation. Ala. Code § 13A-6-1 (LEXIS through 2005 First Spec. Sess.); Ind. Code §§ 35-42-1-1, -3, -4 (LEXIS through 2005 Reg. Sess.); *Commonwealth v. Lawrence*, 536 N.E.2d 571 (Mass. 1989); *Commonwealth v. Cass*, 467 N.E.2d 1324 (Mass. 1984). Others still, such as Kentucky, Louisiana, and Pennsylvania, have enacted additional statutes creating the crimes of feticide or homicide

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§§ 1.205, 565.020, .024 (LEXIS through 2005 Sess.); Neb. Rev. Stat. §§ 28-391 to -394 (LEXIS through 2005 First Sess.); 2006 Neb. Laws 57; Nev. Rev. Stat. § 200.210 (LEXIS through 73d (2005) Sess. and 22d Spec. (2005) Sess.); N.Y. Penal Law § 125.00 (McKinney through L.2006); N.D. Cent. Code §§ 12.1-17.1-01 to -04 (LEXIS through 2005 Sess.); Ohio Rev. Code Ann. §§ 2903.01 to -.07, -.09 (LEXIS through 126th Ohio Gen. Assemb.); Okla. Stat. tit. 21, §§ 652, 713, 714, 723 (LEXIS through 2005 Extraordinary Sess.); 18 Pa. Cons. Stat. 2601 to 2609 (L EXIS through 2005 Legislative Sess.); R.I. Gen. Laws § 11-23-5 (LEXIS through Jan. 2005 Sess.); 2006 S.C. Acts 325; S.D. Codified Laws §§ 22-16-1, -1.1, -15(5), -20, -41 (LEXIS through 2005 legislation); Tenn. Code Ann. §§ 39-13-201, -202, -210, -211, -213 to -215 (LEXIS through 2005 Sess.); Tex. Penal Code § 1.07(a)(26) (LEXIS through 2006 3d Called Sess.); Utah Code Ann. § 76-5-201 (LEXIS through 2006 Third Spec. Sess.); Va. Code Ann. § 18.2-32.2 (LEXIS through 2006 Reg. Sess.); Wash. Rev. Code § 9A.32.060(1)(b) (LEXIS through 2005 Gen. Election); W. Va. Code § 61-2-30 (LEXIS through 2006 First Extraordinary Sess.); Wis. Stat. §§ 939.75, -.24, -.25, 940.01, -.02, -.06, -.08 to -.10 (LEXIS through Jan. 6, 2006). Several states which now provide protection through statute previously provided protection via judicial interpretation of their other homicide laws. See generally, Alan S. Wasserstrom, Annotation, Homocide *Based on Killing of Unborn Child*, 64 A.L.R.5th 671 (Westlaw Update April 2005).

of an unborn child. Ky. Rev. Stat. Ann. §§ 507A.010-.060 (LEXIS through 2005 Reg. Sess.); La. Rev. Stat. Ann. §§ 14:2(11), 14:32.5-.8 (LEXIS through 2006 First Extraordinary Sess.); 18 Pa. Const. Stat. §§ 2601-09 (LEXIS through 2005 Act 96). Whatever their approach, these thirty-five states have sought to protect the right of the unborn to be free from violence and to establish the unborn as individual victims.

Although the Unborn Victims of Violence Act was signed into law in only 2004, criminal penalties for killing a fetus have existed for centuries, dating back to ancient Persia. Louis B. Wright, *Fetus v. Mother: Criminal Liability For Maternal Substance Abuse During Pregnancy*, 36 Wayne L. Rev. 1285, 1291 (1990). While ancient Greek and Roman civilizations did not generally criminalize fetal homicide, there was an exception if "the father's rights to the child had been violated." *Id.* The common law also recognized fetal homicide as a crime, but only if the baby was born alive and subsequently died as a result of injuries sustained while in utero. Sir William Blackstone, *Commentaries on the Laws of England*, 944 (3rd ed. 1903). The "born alive rule" has existed since at least 1368 primarily because of the difficulty of determining the cause of death of an unborn child. Robert M. Byrn, *An American Tragedy: The Supreme Court on Abortion*, 41 Fordham L. Rev. 807, 815-827 (1973). As Sir William Blackstone put it:

> To kill a child in its mother's womb, is now no murder, but a great misprision: but if the child be born alive, and dieth by reason of the potion or bruises it received in the womb, it seems, by the greater opinion, to be murder in such as administered or gave them.

Id. Just because the "born alive rule" was necessary prior to advances in mortuary science does not mean that the rule must continue. In the words of Oliver Wendell Holmes, Jr.

> It is revolting to have no better reason for a rule of law than that so it was laid down in the time of Henry IV. It is still more revolting if the grounds upon which it was laid down have vanished long since, and the rule simply persists from blind imitation of the past.

Address by Oliver Wendell Holmes, Jr., 10 Harv. L. Rev. 457, 469 (Jan. 8, 1897).[4]

Contrary to popular belief, the prospect of criminal penalties for the violence against the unborn is not a recent phenomenon. The modern movement to enact fetal homicide laws dates to the early 1970's. In 1970, when a California man learned of his ex-wife's pregnancy by another man, he accosted her on a mountain road, pulled her out of her car and told her "I'm going to stomp it [the baby] out of you!" *Keeler v. Superior Court*, 470 P.2d 617, 618 (Cal. 1970). He proceeded to assault her, ramming his knee into her abdomen. *Id.* The child, thirty-four to thirty-six weeks gestation, was stillborn with a fractured skull later that day. *Id.* Keeler was charged with multiple criminal counts including murder of the baby. *Id.* The California Supreme Court, following the common law "born alive" rule, said a fetus was not a human being within the provision of Calaifornia Peanl Code § 187.

This ruling sparked a legislative battle in California to change the murder statute, unaltered since 1872, to add "or a fetus" to those protected under the murder statute. Assemb. B. 816, 1970 Reg. Sess. (Ca. 1970). Borden D. Webb, *Is The Intentional Killing of An Unborn Child*

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[4] For a review of states that previously or still import the common law born alive doctrine into various statutes through judicial interpretation (including both states with and without additional statutory protection), see, Alan S. Wasserstrom, Annotation, Homocide *Based on Killing of Unborn Child*, 64 A.L.R.5th 671 (Westlaw Update April 2005).

Homicide? California's Law to Punish The Willful Killing of a Fetus, 2 Pac. L. J. 170, 172 (1971). The original intent by the bill's author was to define a human being to include a fetus of at least twenty-weeks. *Id.* at 172. However, the legislature ultimately decided not to define fetus and leave the definition up to the courts. *Id.* at 183. This landmark legislation was quickly passed, only eight weeks after the *Keeler* decision. Anna Hua Hsu, *From Keeler v. Superior Court to People v. Davis: The Definition of Fetal Murder in California*, 23 W. St. U.L. Rev. 219 (1995).

After *Keeler* and the amendment of California Penal Code §187 in 1970, the California Courts of Appeals rendered numerous opinions defining "fetus" under the murder statute. *Id.* However the definition was not settled for almost a quarter century until the California Supreme Court addressed the issue in its decision in *People v. Davis*, 872 P.2d 591, 593 (1994). The court ultimately determined that viability was "not an element of fetal murder." *Id.* In its analysis, the court quoted *Roe v. Wade*, 410 U.S. 113 (1973), noting that the state has interests other than the rights of a woman, namely an "important and legitimate interest in protecting the potentiality of human life." *Id.* at 599.

On the other hand, one state, Massachusetts has not enacted legislation, but nonetheless provides protection of unborn life via judicial decision. In *Commonwealth v. Cass*, 467 N.E.2d 1324 (Mass. 1984), the defendant, who was driving at a high rate of speed, hit a pedestrian who was more than eight months pregnant, killing the baby within the womb. *Id.* The Supreme Judicial Court held that a fetus was included within the purview of the definition of "person" under the homicide statute. *Id.* (However, the court applied this definition prospectively only because of the potential that that defendant had "relied on the old rule.") *Id.* at 1328.

The court gave multiple rationales for extending its vehicular homicide statute to include the unborn. The first reason the court gave was that since the Massachusetts legislature had previously determined that a fetus was a

person for civil, wrongful death actions, it was presumably aware of its own definition of person and intended it to apply to homicide as well. Major Michael J. Davidson, *Fetal Crime and Its Cognizability as a Criminal Offense Under Military Law*, 1998 Army Law. 23, 25. Second, the court reasoned that a "person," being synonymous with "human being," included a child of a human, both within and without the womb of that human. *Id.* at 25-26.

In 1989 the Massachusetts Supreme Judicial Court confirmed its 1984 *Cass* decision by upholding a district court opinion in an appeal from a man convicted of the first degree murder of his sixteen year old girlfriend and involuntary manslaughter of her twenty-seven week old fetus. *Commonwealth v. Lawrence*, 536 N.E.2d 571 (Mass. 1989).[5]

After California's pioneering efforts and Massachusetts' unique judicial approach, the most important historical development to note is the recent flurry of state enactments. Many of these recent statutes listed in footnote 3 above (as well as the federal Unborn Victims of Violence Act, mentioned previously) were enacted in response to the highly publicized murders of Laci and Connor Peterson. Holly Auer, *Fetal Homicide Laws Stir Debate*, Post and Courrier (Charleston, S.C.), Mar. 14, 2006, at A1.

As noted above, the Partial Birth Abortion Ban Act, 18 U.S.C. § 1531 (LEXIS through Pub. Law 109-245), is a logical extension of the Unborn Victims of Violence Act. The Unborn Victims of Violence Act recognizes the individuality of unborn children and protects them from "external" violence. The Partial Birth Abortion Ban Act goes on to protect unborn children from particularly violent form of abortion. In making this extension, Congress

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[5] For other states that previously provided or still provide protection via judicial interpretation of homicide statutes see Alan S. Wasserstrom, Annotation, Homicide *Based on Killing of Unborn Child*, 64 A.L.R.5th 671 (Westlaw Update April 2005).

followed the pattern of both the Unborn Victims of Violence Act and the majority of the state fetal homicide laws which contained a maternal exception to shelter mothers from prosecution. Therefore, the Partial Birth Abortion Ban Act also contained a maternal exception.[6]

Not only have Congress and the majority of state legislatures recognized that an unborn child may be a separate victim of a violent attack, but the courts have universally upheld such statutes as constitutional. For example, in Missouri Revised Statutes § 1.205 (2006), the Missouri General Assembly declared that "the laws of [Missouri] shall be interpreted and construed to acknowledge on behalf of the unborn child at every stage of development, all the rights, privileges, and immunities available to other persons, citizens, and residents of this state . . . ." This statute contains findings of that "(1) [t]he life of each human being begins at conception; (2) [u]nborn children have protectable interests in life, health, and well-being; [and] (3) [t]he natural parents of unborn children have protectable interests in the life, health, and well-being of their unborn children." *Id.* This Court, in *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989), upheld the statute, holding that there was no facial conflict between the Missouri statute and *Roe v. Wade.*

Other courts have upheld state fetal homicide statutes against other challenges. *Eg., People v. Davis*, 872 P.2d 591, 593, 599 (Cal. 1994) (challenge, based on *Roe*, to state legislature's addition of fetus to the murder statue and viability as an element failed); *People v. Dennis*, 950 P.2d 1035, 1058-59 (Cal. 1994) (challenge to capital punishment as cruel and unusual for killing a fetus failed); *Smith v.*

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6 The Unborn Victims of Violence Act also contains an abortion exception. One might argue that this exception negates the argument being made here. However, the abortion exception is applicable only to *legal* abortions. The Partial Birth Abortion Ban Act seeks to make a certain kind of abortion illegal and thus does not conflict with the Unborn Victims of Violence Act.

Newsome, 815 F.2d 1386, 1387-88 (11th Cir. 1987) (challenge to Georgia's feticide statute based on *Roe*, equal protection, and unconstitutional vagueness failed); *Brinkley v. State*, 322 S.E.2d 49, 51-52 (Ga. 1984) (challenge to unconstitutional vagueness and due process failed); *People v. Ford*, 581 N.E.2d 1189, 1199-1201 (Ill. App. Ct. 1991) (challenge based on equal protection and unconstitutional vagueness failed); *State v. Smith*, 676 So. 2d 1068, 1071-72 (La. 1996) (challenge based on double jeopardy failed); *State v. Merrill*, 450 N.W.2d 318, 321-24 (Minn. 1990) (challenge based on equal protection and unconstitutional vagueness failed); *State v. Bauer*, 471 N.W.2d 363 (Minn. App. 1991) (challenge based on establishment clause failed); *Pennsylvania v. Bullock*, 868 A.2d 516, 521-23 (Pa. Super. Ct. 2005) (challenge based on *Roe*, equal protection and unconstitutionally vague failed); *Pennsylvania v. Wilcott*, No. 2426 A & B of 2002 (Court of Common Pleas of Erie County, Pennsylvania, Criminal Division) (challenge to Pennsylvania's Crimes Against Unborn Children Act as unconstitutionally vague, violative of U.S. Supreme Court abortion cases and due process failed); *Utah v. MacGuire*, 84 P.3d 1171, 1174-75 (Utah 2004) (challenge as unconstitutionally vague failed); *State* v. *Black*, 526 N.W.2d 132, 134 (Wis. 1994) (challenge to due process failed).

As the above discussion demonstrates, it is widely established that unborn children may be treated as distinct individuals deserving of legislative protection. Courts, including this Court, have consistently upheld this legislative determination. Congress, in enacting the Partial Birth Abortion Ban Act, recognized, at least implicitly, that if unborn children may be victims when their right to life is violated through "external" violence, then they would also be victims when their right to life is violated through partial birth abortions. To strike down the Partial Birth Abortion Ban Act would therefore be inconsistent with the permissible legislative goal of protecting the unborn from acts of violence

CONCLUSION

For the foregoing reasons, this Court should reverse the judgment of the Court of Appeals.

Respectfully submitted,

This 3rd day of August, 2006

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Nos. 05-380, 05-1382

In the Supreme Court of the United States

ALBERTO R. GONZALES, ATTORNEY GENERAL,
Petitioner,

v.

LEROY CARHART, ET AL.,
Respondents.

ALBERTO R. GONZALES, ATTORNEY GENERAL,
Petitioner,

v.

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., ET AL.,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURTS OF APPEALS FOR THE EIGHTH AND NINTH CIRCUITS

MOTION FOR LEAVE TO FILE OUT OF TIME IN CASE NO. 05-380 BRIEF AMICI CURIAE AND BRIEF AMICI CURIAE FOR THE NATIONAL WOMEN'S LAW CENTER AND 31 OTHER ORGANIZATIONS COMMITTED TO THE SAFEST HEALTH CARE FOR WOMEN SUPPORTING RESPONDENT IN CASE NO. 05-1382

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MOTION FOR LEAVE TO FILE BRIEF OF *AMICI CURIAE* OUT-OF-TIME IN *GONZALES V. CARHART*, NO. 05-380

On February 21, 2006, this Court granted *certiorari* in *Gonzales v. Carhart*, No. 05-380, to review the judgment of the Court of Appeals for the Eighth Circuit striking down the Partial Birth Abortion Ban Act of 2003, Pub. L. No. 108-102, 117 Stat. 1201 (the "Act") (to be codified at 18 U.S.C. § 1531). The Court has granted *certiorari* in the instant case, *Gonzales v. Planned Parenthood Federation of America*, No. 05-1382, to review the judgment of the Court of Appeals for the Ninth Circuit also striking down the Act.

Amici curiae the National Women's Law Center and 31 other organizations committed to the safest health care for women have submitted this brief in *Gonzales v. Planned Parenthood Federation of America* with the consent of Petitioner and Respondents, in order to explain how the Act limits a woman's ability to secure the safest health care option for her – and the option that she may choose for personal, moral, and religious reasons as well – and to describe the variety of serious adverse consequences to women's health, financial security, and future well-being that can result from the Act.

Gonzales v. Carhart raises the same constitutional questions, concerns the same Act of Congress, involves the same Petitioner, and will be argued on the same day as *Gonzales v. Planned Parenthood Federation of America*. The information and arguments presented in this brief *amici curiae* are equally relevant to both cases.

Petitioner Gonzales has consented to the filing of this brief *amici curiae* in *Gonzales v. Carhart* as well as in *Gonzales v. Planned Parenthood Federation of America*. Petitioner will not be prejudiced in any way by the granting of this Motion, because he will have the opportunity to respond to this brief in his Reply Brief.

For these reasons, *amici* request that the Court grant them leave to file this jointly-captioned brief in support of Respondents in *Gonzales v. Carhart* as well as in support of Respondents in *Gonzales v. Planned Parenthood Federation of America*. *Amici* further respectfully request that the Court direct the Clerk to accept this brief out-of-time in *Gonzales v. Carhart* and to docket the brief in both cases.

Respectfully submitted,

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INTEREST OF THE *AMICI CURIAE*

Amici curiae are organizations committed to obtaining full legal and social equality for women, including access to the full range of the safest, medically-approved health care. *Amici* write to highlight the ways in which the Partial Birth Abortion Ban Act of 2003, Pub. L. No. 108-102, 117 Stat. 1201 (the "Act") (to be codified at 18 U.S.C. § 1531), limits a woman's ability to secure the safest health care option for her – the option that she may choose for personal, moral, and religious reasons as well. *Amici* also write to describe the variety of serious adverse consequences to women's health, financial security, and future well-being that can result from the Act, which limit women's ability to participate fully and equally in society. The names and individual statements of interest of *amici* are contained in the appendix to this brief.[1]

SUMMARY OF ARGUMENT

1. The evidence presented by a host of respected physicians in the cases challenging the Act demonstrates that women may be virtually unable to obtain any safe abortion at all during and after the fourth month of pregnancy because of the Act's broad reach, and, even if narrowly construed, the Act can deny women access to the safest available procedure. In addition to being unconstitutional under *Stenberg v. Carhart,* 530 U.S. 914 (2000), and a long line of other decisions of this Court,

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[1] Letters of consent have been filed with the Clerk reflecting consent for both *Gonzales v. Planned Parenthood Fed'n of Am.*, No. 05-1382, and *Gonzales v. Carhart*, No. 05-380. No counsel for a party authored this brief in whole or in part, and no person or entity other than *amici*, their members, or their counsel made a monetary contribution to the preparation or submission of this brief.

this threat to women's health has serious potential adverse consequences that can continue throughout a woman's life and that perpetuate the historically unequal status and economic condition of women in our society. Adverse health consequences can include debilitating conditions requiring invasive and expensive medical procedures, problems with future pregnancies, permanent infertility, and other serious health impairments, and even death. These health consequences can lead to women's loss of jobs and wages, their inability to secure health insurance and adequate health care in the future, and can impair their ability to care for their families and themselves.

2. The Act violates due process because it represents an unwarranted intrusion into a woman's most personal choices for impermissible reasons. It not only denies women access to safe health care, but also improperly substitutes the government's view of morality for the strongly held personal, moral and religious beliefs of the woman. The Act bars a woman who may be facing grave risks to her own health and a tragic medical condition of her fetus from access to a procedure that she believes is the most humane, and which allows her to hold and grieve over her fetus in accord with her deepest personal desires and the moral and religious dictates of her conscience. Her beliefs, along with her determination to preserve her ability to bear children in the future and avoid other serious adverse health consequences, require respect under the Constitution.

As this Court recently affirmed in *Lawrence v. Texas*, 539 U.S. 558 (2003), the government may not intrude into individuals' most private choices based solely on its own moral judgment. "Our obligation is to define the liberty of all, not to mandate our own moral code." *Id.* at 571 (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 850 (1992)). *Accord* at 577 (fact that State views a practice as "immoral" is "not a sufficient

reason for upholding a law prohibiting the practice") (quoting *Bowers v. Hardwick*, 478 U.S. 186, 216 (1986) (Stevens, J., dissenting)). The prohibition against government intrusion is especially strong when the government's imposition of its own moral code not only ignores the moral code of the woman involved, but also has serious adverse consequences for the well-being of the woman and her family.

The State's interference on "moral" grounds with women's most personal health care decisions and the implications that interference raises for women's equal participation in society echo the "personal dignity" and "equality" concerns that led the Court to find that the Texas sodomy law at issue in *Lawrence* was unconstitutional – the right of individuals to participate fully and fairly in society and their right to make personal choices "and still retain their dignity as free persons." *Id.* at 567, 575.

3. Denying women access to a medical procedure that represents the safest medical option, and one they might also choose for deeply personal, moral or religious reasons, further violates women's right to due process because it interferes with their basic bodily integrity. *See, e.g., Casey*, 505 U.S. at 849 ("It is settled now, as it was when the Court heard arguments in *Roe v. Wade*, that the Constitution places limits on a State's right to interfere with a person's most basic decisions about family and parenthood as well as bodily integrity.") (citations omitted); *id.* at 884 (abortion right "justified" by "the right to physical autonomy"). Just as the government may not force anti-psychotic drugs on a non-dangerous inmate, *Washington v. Harper,* 494 U.S. 210, 221-222, 227 (1990), or pump a suspect's stomach for evidence, *Rochin v. California*, 342 U.S. 165, 173-74 (1952), the government here may not force a woman to endure a more invasive and more dangerous procedure in order to obtain an abortion after the first trimester, or, because of the

breadth of the Act, to bar her access to virtually any procedure at all.

ARGUMENT

I. THE ACT'S UNCONSTITUTIONAL DENIAL OF WOMEN'S ACCESS TO THE BEST AND SAFEST HEALTH CARE CAN HAVE SERIOUS ADVERSE CONSEQUENCES

In *Stenberg*, 530 U.S. 914, this Court invalidated Nebraska's "partial birth abortion" ban because it lacked the constitutionally-required exception permitting the procedure when necessary to preserve a woman's health. *See Ayotte v. Planned Parenthood of N. New England*, 126 S. Ct. 961, 967 (2006) ("[O]ur precedents hold[] that a State may not restrict access to abortions that are 'necessary, in appropriate medical judgment, for preservation of the life or health of the mother.'") (citing numerous authorities). This Court held, based on the "highly plausible" evidence before the trial court, that a health exception was necessary because "significant medical authority supports the proposition that in some circumstances, D&X [or intact D&E] would be the safest procedure." *Stenberg*, 530 U.S. at 932. In the six years since the Court decided *Stenberg*, an even stronger medical consensus has developed on the safety advantages of intact D&E. Brief of the American College of Obstetricians and Gynecologists as *Amicus Curiae* Supporting Respondent (hereinafter "ACOG *Amicus* Br.) at 2, 27-28.[2]

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[2] The *only* other context found in which Congress has criminalized a specific medical procedure is the statutory ban on female genital mutilation. *See* 18 U.S.C. § 116 (1996). But, even in the case of female genital mutilation, that statute – unlike the Act – has a health exception. *See id.* § 116(b).

The Court in *Stenberg* also struck down the statute because the definition of the banned procedure was so broad that it applied to what the Court found to be the most common procedure performed in the second trimester. 530 U.S. at 924, 938-946. The vague and broad definition at issue in *Stenberg* is similar in the key respects to the definition in the Act,[3] and the Act therefore creates an undue burden to women seeking abortion in the second trimester under *Stenberg*. *See* ACOG *Amicus* Br. at 21-26. Evidence below demonstrated that doctors fearing criminal liability will be reluctant to perform *any* D&E under the Act's broad language.[4] Indeed, even a Government expert conceded

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[3] Although the government attempted to defend the Act by arguing that there were meaningful differences between the Nebraska law at issue in *Stenberg* and the Act, the Ninth Circuit found that the Act is similar to the state statute in its vague and broad definition. *Planned Parenthood Fed'n v. Gonzales*, 435 F.3d 1163, 1178, 1179 (9th Cir.), *cert. granted*, 126 S. Ct. 2901 (2006) ("despite containing some provisions that are different in form from those in the Nebraska statute, the Act is sufficiently broad to cause those who perform non-intact D&E procedures to 'fear prosecution, conviction, and imprisonment,'" thus unduly burdening women's constitutional rights).

[4] Joint Appendix, *Gonzales v. Planned Parenthood Fed'n of Am.* (hereinafter "PPFA J. App.") 235-36 ("[a]t this point I am currently going to stop doing D&Es"); PPFA J.App. 78-79 ("if I continue to practice ... second trimester abortion, in the way I believe is safest for women, ... I could be in prison"); PPFA J.App. 161-62 ("any D&E that we do could end up falling under that definition [in the Act]"); *see also* PPFA J.App. 137-38, 139-40, 256, 307-08, 445, 451, 525-26); Joint Appendix, *Carhart v. Gonzales* (hereinafter "Carhart J.App.") 201-02, 611-12, 643-47, 733-34, 851-58.

that, in light of its ambiguities, the Act could well be construed to "outlaw all D&Es." Carhart Eighth Circuit Pl.App. 489.[5]

Adverse health and other consequences to women that may result from the Act are described below. These consequences are premised on the government's incorrect argument that the Act's ban is limited to the intact D&E procedure. However, the risks are magnified many times over when the true reach of the Act to virtually all second trimester abortions is considered.[6]

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[5] Moreover, in practice a physician may not be able to determine before the abortion begins whether an intact or non-intact D&E procedure will actually be performed. PPFA J.App. 143, 220, 281, 306, 438, 440, 413. *Accord* ACOG *Amicus* Br. at 4-7, 23-24.

[6] *Planned Parenthood Fed'n,* 435 F.3d at 1166 (D&E "accounts for 85 to 95 percent of" post-first trimester abortions). If all D&E procedures are banned, the alternative procedure for most women would be an "induction abortion" – essentially a simulated labor. But the Act could cover inductions as well. If complications or health issues develop during the course of an induction, the doctor would be required to complete the procedure with instruments, violating the Act for the same reasons as a D&E. Similarly, if the fetus' head lodges in the vaginal canal, the doctor would typically reduce the size of the skull, also violating the Act. *See Planned Parenthood Fed'n of Am. v. Ashcroft*, 320 F. Supp. 2d 957, 977 (N.D. Cal. 2004) (Act "may be interpreted to comprise many acts performed ... in the course of ... an induction."). *Accord* ACOG *Amicus* Br. at 25-26; PPFA J.App. 526-27. Even if the woman is able to obtain the induction procedure, induction abortions typically require a hospital stay, take many hours, present increased risk in some circumstances and are medically inappropriate in others. PPFA J.App. 85-86, 131, 224, 266-68, 375-76, 389-92, 514-15, 571-72, 721-22; ACOG *Amicus* Br. at 7.

A. Substantial Evidence Demonstrates That an Intact D&E Can Be The Safest and Best Option for Women's Health

Substantial record evidence shows the intact D&E procedure that the Act forbids is essential if women and their doctors are to have access to the safest means of terminating a pregnancy after the first trimester. Testimony from a variety of respected physicians shows that the intact D&E procedure is part of accepted medical practice, and as such is taught at leading teaching hospitals across the country,[7] that it presents important safety advantages for all women,[8] and that it is medically necessary for some.[9] This evidence is recounted in full in the Respondents' Briefs in these cases, in the ACOG *amicus* brief, and in the *amicus* brief submitted by the National Abortion Federation in *Carhart* recounting the evidence in the New York district court proceeding. It is evidence that builds on, updates, and reinforces the "highly plausible" evidence that this Court recognized in *Stenberg* when it held that a health exception was necessary because "significant medical authority supports the proposition that in some circumstances D&X [or intact D&E] would be the safest procedure." 530 U.S. at 932. And, it is evidence that has been found convincing by the two district courts whose decisions were affirmed

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[7] PPFA J.App. 450-51 (intact D&E taught at Columbia University, New York University, Cornell, Albert Einstein College of Medicine, Northwestern University, and others); App. to Petit. For Cert, *Carhart v. Gonzales* (hereinafter "Carhart P.App.") 217a, 219a (government witness conceding he planned to permit intact procedures at Yale University School of Medicine); Carhart J. App. 137, 402, 459-60, 570, 728-29, 743-44, 788-89, 872.

[8] *See infra* notes 11, 12, 15.

[9] *See infra* notes 13, 14.

in the Eighth and Ninth Circuit decisions before the Court.[10]

For all women, the intact D&E procedure provides certain health and safety benefits. Among other advantages, it minimizes the risk of perforation of the uterus, laceration of the cervix, infection, and hemorrhage.[11] As detailed in Respondents' briefs, a peer-reviewed study supports the conclusion that intact procedures offer lower risk of complications and other safety advantages.[12] When a woman has certain underlying medical conditions, the medical benefits of the

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[10] *Planned Parenthood Fed'n*, 435 F.3d at 1167-68 (district court found that "intact D&E is in fact the safest medical option for some women in some circumstances" and that "intact D&E may be significantly safer than other D&E procedures"); *Carhart v. Ashcroft*, 331 F. Supp. 2d 805, 1016 (D. Neb. 2004) ("the trial evidence establishes that a large and eminent body of medical opinion believes that partial-birth abortions provide women with significant health benefits in certain circumstances"); *Carhart v. Gonzales*, 413 F.3d 791, 801-02 (8th Cir. 2005), *cert. granted*, 126 S. Ct. 1314 (2006). *Accord National Abortion Fed'n v. Gonzales*, 437 F.3d 278, 281-82 (2d Cir. 2006) ("substantial medical authority indisputably exists" that "banning [the intact D&E procedure] could endanger women's health").

[11] PPFA J.App. 74-76, 116-19, 127-29, 131, 214, 220-21, 277-79, 371, 374, 423-27, 430, 438, 483-84, 497-98, 499-501; Carhart P.App. 47a, 69a, 78a, 83a-85a, 88a, 90a, 99a-100a, 107a, 118a-20a; 123a, 132a, 145a, 149a-50a, 155a-60a, 166a, 169a-72a, 174a, 179a, 182a, 189a, 193a, 195a-265a-66a, 279a-88a, 358a-59a, 400-01a, 473a-74a, 434a-35a.; App. in Opp. to Cert., *Carhart v. Gonzales* (hereinafter "Carhart R.App.") 81-87; Carhart J.App. 45-46, 137-39, 225-27, 532-35, 604, 634-35, 695, 696, 757-60, 848-51, 892. *Accord* ACOG *Amicus* Br. at 2, 11-12.

[12] PPFA J.App. 497-98, 1055 (Stephen T. Chasen, et al., *Dilation and Evacuation at >20 Weeks; Comparison of Operative Techniques*, 190 Am. J. Obstet. & Gynecol. 1180 (2004)).

intact D&E are even more significant. Among these conditions are placenta previa or accreta, liver disease, and certain infections, including chorioamnionitis (an infection of the fetal membranes that spreads to the fetus, placenta, and uterine lining), and sepsis (a severe systemic infection). Each of these conditions can increase the possibility of hemorrhage, meaning that a procedure with less risk of perforation or laceration and a shorter duration is indicated.[13] Other women for whom the intact D&E can be medically indicated are women with toxemia, heart problems, cancer of the placenta, pulmonary hypertension, and vascular disease.[14] Indeed, even the Government's witnesses conceded that the intact D&E procedure could minimize risk and be the safest alternative in some circumstances.[15]

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[13] PPFA J.App. 289, 291, 299-300, 375, 506-07, 509-10; Carhart P.App. 288a-91a; Carhart J.App. 711-13, 770-71. *Accord* ACOG *Amicus* Br. at 2, 13-16.

[14] PPFA J.App. 294, 503, 506-07; Carhart P.App. 99a-100a, 110a-13a, 290a-91a, 434a-35a, 448a, 481a; Carhart J.App. 768-74; Carhart PX 120, 537-38, 540-42; Carhart PX 121, 1600-01.

[15] *E.g.*, PPFA J.App. 720 (testimony of Dr. Shadigan agreeing that "there is always a risk of damage to the uterus" when instruments are passed into it, and that "removal of the fetus intact during a surgical procedure" would "reduce" the risk of "fetal bones puncturing or lacerating the uterus"); PPFA J.App. 727 (testimony of Dr. Shadigan agreeing that "intact D&E may minimize trauma to the woman's uterus, cervix and other vital organs"); PPFA J.App. 780-82 (testimony of Dr. Cook that "at comparable gestational ages ... it would make sense that anything that involves less instrumentation would reduce the risk of laceration or perforation"); PPFA J.App. 570-71 (testimony of Dr. Bowes agreeing that a "technique that reduces the number of insertions into the uterus might offer some safety advantages"); Respondent's Eighth Circuit Ct. of Appeals App., *Carhart v. Gonzales*, 403 (Testimony of Dr. Cook that intact D&E "may be preferable procedure at the same gestational age

Evidence before Congress as it considered the Act demonstrates that many women undergo the intact D&E procedure, based on the advice of their doctors, because they believe it is the best procedure to address their particular health needs. For example:

Vikki Stella, a diabetic, discovered during her 32nd week of pregnancy that the fetus she was carrying suffered from "at least nine major anomalies, including a fluid-filled cranium with no brain tissue at all" and that consequently it "would never have survived outside [her] womb." *See The Partial Birth Abortion Ban Act of 1995:* Hearing Before the Senate Comm. on the Judiciary, 104th Cong., 1st Sess. 280 (1995) (hereinafter, the "1995 Senate Hearing"). Because of potential complications related to her diabetes, Ms. Stella's doctor determined an intact D&E was the safest procedure for her. *See id.* at 281 That procedure not only protected her from immediate medical risks, but also ensured that she would be able to have more children. *See id.* The procedure was effective and safe, and Ms. Stella was nearly eight months into a new pregnancy when she testified. *See id.* at 280.

Claudia Crown Ades discovered in her second trimester that her fetus had a genetic disorder known as trisomy 13, which caused the fetus to have "a fluid filled non-functional brain" and a "malformed heart with a large hole between the chambers that was preventing normal blood flow." *Id.* at 283. As Ms. Ades reported, her doctor and two specialists (a perinatologist and a geneticist) advised her and her husband Richard that an

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than a D&E, if you are able to have less need for instrumentation inside the uterus"); Carhart J.App. 474, 424-25, 433 (testimony of Dr. Lockwood agreeing that for women with chorioamnionitis or placenta previa who also had viral infection, intact D&E may be best alternative and safe alternatives are not always available); *see also* Carhart J.App. 280-81, 418-19, 466, 545-47; Carhart P.App. 325a-88a, 394a, 470a, 502a-03a.

intact D&E "would be the safest [course of action] for me, my baby, and for my future children." *Id.* at 284. Mr. Ades further explained to Congress: "I don't know what I would have done without this medical option.... I knew, after all the discussions, deliberations and questioning that both Claudia and I did, that an Intact D&E was the safest, most humane procedure available to our family. For that, I am grateful." *Id.* at 286.

Coreen Costello, a self-identified conservative, testified that during the seventh month of her third pregnancy she began having premature contractions. Her doctors determined that her fetus was suffering from a lethal neurological disorder. *See Effects of Anesthesia During a Partial Birth Abortion:* Hearing Before the Subcomm. on the Constitution of the H. Comm. on the Judiciary, 104th Cong., 2d Sess. 320 (1996) (hereinafter, the "1996 House Hearing"). Because of their deeply-held religious beliefs, the Costellos wanted to deliver their baby naturally, but during the weeks waiting for a natural birth, Ms. Costello's health worsened. *See id.* at 320-22. After much anguish, Ms. Costello accepted her physician's recommendation that she have an intact D& E abortion as the most appropriate option for her. *See id.* Ms. Costello concluded her testimony: "If you outlaw this procedure, other women like me ... may lose their ability to have more children. They may lose their health. They may lose their lives." *Id.* at 323.

Viki Wilson, a registered nurse, learned that two-thirds of the brain of her fetus "had formed on the outside of her skull" and she and her husband faced the possibility of a birthing process in which Ms. Wilson's cervix likely would be ruptured. *See* 1995 Senate Hearing at 160-61. Her doctor also determined that "a C section in [Ms. Wilson's] condition [was] too dangerous," and that he could not "justify those risks." *Id.* at 161. As she recounted, after much prayer and deliberation, Ms. Wilson and her husband reached the conclusion that the intact D&E procedure was the safest solution for her and

a humane solution for the fetus. *See id.* In her words, the procedure now criminalized by the Act was their "salvation." *Id.* at 161-62.

Mary-Dorothy Line and her husband learned that their fetus had advanced hydrocephaly and an undeveloped stomach. *See* 1996 House Hearing at 328. Her doctors told her that an intact D&E was "the best and safest procedure" to "preserve [her] body for future pregnancies." *Id.* She testified that the procedure "gave us hope" for future pregnancies and asked Congress, "Please don't take that away from the families who will need it after us." *Id.* at 329. Ms. Line was expecting another baby when she testified. *Id.*

Tammy Watts testified before the House concerning her experience with the devastating trisomy-13 syndrome. *See Partial-Birth Abortion*: Hearing Before the Subcomm. on the Constitution of the H. Comm. on the Judiciary, 104th Cong., 1st Sess. 71 (1995) (hereinafter, the "1995 House Hearing"). After her doctor and an additional specialist confirmed that the fetus had "no eyes," "enlarged kidneys [that were] already failing," and a "mass on the outside of her stomach involv[ing] her bowel and bladder," Ms. Watts and her husband recognized that their much-wanted child would never survive. *See id.* at 72. In addition, the continuation of Ms. Watts' pregnancy posed grave risks to her health, including stroke, paralysis, infertility or even death.[16] In consultation with a genetic counselor, she and her husband opted to terminate the pregnancy:

> I had a choice. I could have carried this pregnancy to term, knowing that everything

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16 *See* Remarks by the President on House Resolution 1833, *available at* http://www.pbs.org/newshour/bb/white_house/abortion_veto_4-10.html; Molly M. Ginty, Late-Term Abortion Saved these Women's Lives, Women's eNews, Oct. 28, 2004, *available at* http://womensenews.org/article.cfm/dyn/aid/2046.

> was wrong. I could have gone on for 2 more months doing everything that an expectant mother does, but knowing my baby was going to die, and would probably suffer a great deal before dying. My husband and I would have to endure that knowledge and watch that suffering. We could never have survived that, and so we made the choice together, my husband and I, to terminate this pregnancy.

Id. at 72. Concluding her testimony, Ms. Watts implored Congress not to ban the procedure that had spared her, her fetus, and her family so much pain: "[Y]ou can't take this away from women and families. You can't. It is so important that we be able to make these decisions, because we are the only ones who can." *Id.* at 73.

B. Denying Women Access to the Safest Medical Procedures Can Cause Permanent Damage to their Health and Harm Their Ability to Work, Care for Their Families, and Secure Their Economic Future

Precluding women from obtaining intact D&E's endangers their health and intrudes on their most personal family decisions, with life-long adverse consequences.[17] For example, a woman who suffers from hemorrhage or infection from a perforated uterus or lacerated cervix – because the intact procedure most likely to avoid those complications was outlawed – could face hospitalization and surgery, including a possible hysterectomy.[18] Additional severe adverse health

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[17] Those consequences are even more widespread and devastating given the true reach of the Act.

[18] *See* F. Gary Cunningham, M.D. et al., *Williams Obstetrics*, 598, 769-70 (20th ed. 1997); *see also* Gary A. Dildy, III, M.D. et

consequences that could arise from hemorrhage or infection include stroke, renal failure, organ failure, and even death.[19]

These potentially serious health consequences, and even the less severe complications that could result from a less safe procedure, can have a devastating impact on a woman's life. Maintaining one's health is often critically important to maintaining employment.[20] National studies show that non-elderly adults in poor health are "less than half as likely to work [compared to someone in excellent health], and if they did work, their hourly wage was about 23% lower."[21] A woman's inability to work, or a serious reduction in her wages, can be catastrophic to her and her family's economic security. Nearly one-fourth of women live in female-headed households and are the sole breadwinner.[22] In married-couple households,

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al., *Critical Care Obstetrics* 307 (4th ed. 2004). *Accord* ACOG *Amicus* Br. at 10-13; PPFA J. App. 265; Carhart P.App. 481a, 497a; Carhart Resp. App. in Opp. to Cert. 81-87 (uterine perforation can result in "catastrophic hemorrhage" requiring hysterectomy).

[19] *See* Cunningham, *supra* note 18, at 547, 558-60, 745-46, 763, 794, 1069-70 and 1140; see also Critical Care Obstetrics, *supra* note 18, at 298, 329-30, and 555. *Accord* ACOG *Amicus* Br. at 10-12.

[20] Cathy Schoen, Lisa Duchon, & Elisabeth Simantov, *The Link Between Health and Economic Security for Working-Age Women* (The Commonwealth Fund, New York, N.Y.), May 1999, *available at* http://www.cmwf.org/usr_doc/healtheconomic_brief.pdf.

[21] Hadley, Jack, *Sicker and Poorer – The Consequences of Being Uninsured: A Review of the Research on the Relationship between Health Insurance, Medical Care Use, Health, Work, and Income*, Medical Care Research and Review, at 85, 60(2) Supp. June 2003.

[22] U.S. Census Bureau 2004 Current Population Survey.

wom.n's earnings constitute a median of more than one-third (35%) of the family's income,[23] and in about one-fifth of all married couple families, women are the primary wage earner.[24] The median earnings of all women in the workforce are low and have stagnated while poverty among women has increased and deepened in the last five years.[25] A lack or reduction of wages could push more women and their families closer to poverty and others deeper into the poverty they endure.

Even when a woman plagued with health complications is able to keep a job, the costs to her, her family and her future prospects can be great. Increased hospitalization and debilitation, for example, can mean at a minimum time off from work that women can ill-afford. Over 42 percent of all private-sector workers do not have any paid sick leave at all.[26] Women, as compared to men,

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[23] U.S. Department of Labor, Bureau of Labor Statistics, Table 24, "Contribution of wives' earnings to family income, 1970-2003," Women in the Labor Force: A Databook, *available at* http://www.bls.gov/cps/wlf-table24-2005.pdf (May 2005),

[24] U.S. Census Bureau, Table F-22, "Married-Couple Families with Wives' Earnings Greater Than Husbands' Earnings: 1981 to 2004 (selected years)," Historical Income Tables – Families, *available at* http://www.census.gov/hhes/www/income/histinc/f22.html; U.S. Department of Labor, Bureau of Labor Statistics, Table 25, "Wives Who Earn More Than Their Husbands, 1987-2003," Women in the Labor Force: A Databook, *available at* www.bls.gov/cps/wlf-table25-2005.pdf (May 2005).

[25] Losing Ground: An Overview of Poverty, Income and Health Insurance Trends Among Women, 2000-2005 (National Women's Law Center, Washington, D.C.), Sept. 2006, *available at* http://www.nwlc.org/pdf/IncomePoverty3.pdf.

[26] U.S. Bureau of Labor Statistics, U.S. Dep't of Labor, Women in the Labor Force: A Databook 2 (May 2005), *available at* http://www.bls.gov/cps/wlf-databook-2005.pdf.

represent larger proportions of minimum wage and part-time workers,[27] who are most likely to lack paid sick leave. Other types of paid leave often cannot be used as an alternative, since from approximately one-quarter to two-thirds of workers lack paid annual or personal leave.[28] Even unpaid leave is not an option for a great number of Americans. Forty percent of American workers are not eligible for the job-protected, unpaid leave guaranteed by the Family and Medical Leave Act.[29] For women workers facing health complications this lack of leave means not only a loss of wages, but can even mean the loss of a job. [30]

Beyond lost jobs and wages, women in poor health may be unable to care for their children and families. It

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[27] U.S. Bureau of Labor Statistics, U.S. Dep't of Labor, Women in the Labor force: A Databook 2 & tbls. 20 & 26 (May 2005), available at http://www.bls.gov/cps/wlf-databook-2005.pdf

[28] U.S. Bureau of Labor Statistics, U.S. Dep't of Labor, National Compensation Survey: Employee Benefits in Private Industry, March 2005, at 22 tbl. 18 (Aug. 2005), *available at* http://www.bls.gov/ncs/ebs/sp/ebsm0003.pdf.

[29] Cantor, David et al., "Balancing the Needs of Families and Employers: Family and Medical Leave Surveys," Report submitted to the U.S. Department of Labor. Washington, DC: Westat (2001).

[30] Employees who are terminated for taking unapproved time off face the problem of lost wages during the entire period of their job search, a problem that can be significant when average unemployment periods last 20 weeks. And women fired for taking unapproved time off may not qualify for unemployment insurance since in most states, the reason for their job termination will not meet qualifying tests. Vicki Lovell, Institute for Women's Policy Research, *No Time to be Sick: Why Everyone Suffers When Workers Don't Have Paid Sick Leave* 5 (2004).

is women who are the primary care givers for family members. Women are an estimated 72 percent of the estimated 15 percent of Americans who are informal care givers, and many of those women are caring both for an ailing relative and caring for their own children.[31] Not only could a woman's disability cause serious dislocation in her family, but it may also have severe economic consequences if paid child or family care must be secured to substitute for care previously given by the disabled woman.

The reduction in income of women left to cope with a serious health condition is exacerbated by the increased health costs and difficulty in obtaining comprehensive, affordable health insurance that she will face. Over one-fifth of women in fair or poor health lack insurance, and one-third of such women delayed or went without care over the course of a year because they could not afford it.[32] Even women with some insurance face problems in securing comprehensive coverage and affording care. Many of these women suffering complications from being unable to obtain the safest second-trimester abortion procedure would now have "pre-existing conditions," which, coupled with rising health care costs and increasing numbers of employers scaling back on health

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[31] Office on Women's Health, Dep't of Health and Human Services, Women's Health Issues: An Overview, May 2000, available at http://www.4woman.gov/owh/pub/womhealth%20issues/index.htm (citing "Majority of Women Control Health Care Decisions", based on a survey conducted by EDK Associates, Merck Media Minutes, Summer 1997).

[32] Kaiser Family Foundation, *Women and Health Care: A National Profile* vi (July 2005), *available at* http://www.kff.org/womenshealth/upload/Women-and-Health-Care-A-National-Profile-Key-Findings-from-the-Kaiser-Women-s-Health-Survey.pdf.

benefits for their employees,[33] only will increase the difficulties they confront. For mounting numbers of women, financial difficulties caused by increased health costs are severe enough to cause bankruptcy.[34]

The Act's disregard for women's health needs and the economic and other consequences that flow from that disdain reinforce the disadvantage and discrimination that this Court has recognized women have historically faced in all aspects of their lives. *See, e.g., Frontiero v. Richardson*, 411 U.S. 677, 684 (1973) ("[O]ur Nation has had a long and unfortunate history of sex discrimination."); *J.E.B. v. Alabama ex rel. T.B.*, 511 U.S. 127, 135 (1994) ("Since *Reed v. Reed,* 404 U.S. 71 (1971), this Court consistently has [recognized] ... the real danger that government policies that professedly are based on reasonable considerations in fact may be reflective of 'archaic and overbroad' generalizations about gender"); *United States v. Virginia,* 518 U.S. 515, 534 (1996) ([Sex]

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[33] According to the 2005 Annual Employer Benefits Survey released by the Kaiser Family Foundation and Health Research and Educational Trust, the percentage of businesses offering health insurance to their workers has declined steadily over the last five years as the costs of providing coverage continues to outpace inflation and wage growth. The Kaiser Family Foundation & Health Research and Educational Trust, *Employer Health Benefits: 2005 Annual Survey* (2005), *available at* http://www.kff.org/insurance/7315/upload/7315.pdf.

[34] Almost half of all personal bankruptcy claims are due to illness and unpaid medical bills. David U. Himmelstein, Elizabeth Warren, Deborah Thorne, & Steffie Woolhandler, *MarketWatch: Illness And Injury As Contributors To Bankruptcy*, Health Affairs, Feb. 2, 2005, *available at* http://content.healthaffairs.org/cgi/content/full/hlthaff.w5.63/DC1. Women are the largest group in bankruptcy. Elizabeth Warren, *What Is a Women's Issue? Bankruptcy, Commercial Law, and Other Gender-Neutral Topics*, 25 Harvard Women's Law Journal 19, 28 (2002).

classifications may not be used, as they once were, to create or perpetuate the legal, social, and economic inferiority of women.") (citation omitted); *Nevada Dep't of Human Res. v. Hibbs,* 538 U.S. 745 (2003) ("All would agree that women historically have been subjected to conditions in which their employment opportunities are more limited than those available to men.") (Kennedy, J., dissenting). Women's legal, social and economic inferiority repeatedly recognized by the Court is reinforced by the Act's adverse effects on women through the absence of a health exception and the undue burden it causes.

II. THE ACT IMPERMISSIBLY IMPOSES ONE MORAL VIEWPOINT ON WOMEN, DENYING THEM PERSONAL DIGNITY AND EQUALITY

Denying women the right to have the best medical care for themselves not only injures their health, it also violates their constitutional due process right to make choices about their personal lives and families free from unwarranted governmental interference. A long line of this Court's precedents, most recently reaffirmed in *Lawrence*, establish that the Government cannot impose restrictions on such decisions based solely on one view of the moral considerations at issue. Women terminating a pregnancy after the first trimester are often faced with very painful and difficult circumstances. As shown above, some women discover that their fetus has a grave health condition; others face serious health issues of their own; others face both concerns.

Some women choose the intact D&E procedure because it enables them to cope with their devastating loss by seeing, holding, and grieving over an intact fetus. Tammy Watts, for instance, who terminated her pregnancy after learning that her fetus had a fatal anomaly, *supra* at 12-13, testified: "Thanks to the type of procedure that Dr. McMahon uses in terminating these

pregnancies, we got to hold her and be with her and love her and have pictures for a couple of hours, which was wonderful and heartbreaking all at once.... We spent some time with her, said our goodbyes." *See* 1995 House Hearing at 72. Ms. Watts also was able to donate the fetal remains for research on the causes of trisomy-13, the fetal anomaly that led to her abortion. *See id.* at 73. "Because Dr. McMahon does the procedure the way he does, it made the testing possible." *Id.*[35] Ms. Watts explained it gave more meaning to her devastating ordeal to know that her fetus could help prevent other women from going through the same experience. *See id.*

Eileen Sullivan, expecting her first child after nearly three years of trying to conceive, learned during her 26th week of pregnancy that her fetus was improperly formed with a number of ailments, including a malformed, failing heart and a malfunctioning liver. *See Partial-Birth Abortion: The Truth*: Joint Hearing Before the Comm. on the Judiciary and the Subcomm. on the Constitution of the H. Comm. on the Judiciary, 105th Cong. 1st Sess. 125 (1997) (hereinafter, the "1997 Joint Hearing"). Ms. Sullivan's doctors explained that the fetus could not survive. When considering her options, Ms. Sullivan emphasized that "[f]or my husband and I, the opportunity to see and touch and hold our child was extremely important." *Id.* at 126. Ms. Sullivan and her husband elected an intact D&E procedure. *Id.* "We were able to say goodbye," she testified. *Id.*

The *amicus* brief filed on behalf of the Institute for Reproductive Health Access and Fifty-Two Clinics and Organizations recounts the story of "Gina," a married, self-described Christian woman who desperately wanted a child, who was pregnant with twins who were

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35 PPFA J. App. 296-97 (testimony of Dr. Broekhuizen) (patient in case of rare fetal anomaly requested intact D&E so that testing and autopsy could be performed).

diagnosed with several fetal anomalies. She prayed, consulted with her pastor, and finally made the decision to undergo an intact D&E – saying that if God could not save her in utero twins, "I wanted to be able to hold them and say goodbye before I lost them forever."[36] *Accord* PPFA J.App. 427 (Dr. Westhoff's testimony that intact procedure allowed woman to hold fetal twins "with clergy and her family present").

Other women choose an intact procedure because they believe it is the humane or compassionate choice for the fetus. *See* 1995 Senate Hearing at 282 (Viki Stella testifying "I did the kindest thing, the most loving thing I knew to do"); *id.* at 286 (Mr. Ades testifying that "[i]ntact D&E was the safest, most humane procedure available to our family"); 1997 Joint Hearing at 159 (Coreen Costello testifying that "the procedure [is] humane [and] dignified"); 1996 House Hearing at 328 (Mary-Dorothy Line testifying that procedure was "safe and very compassionate").[37]

These kinds of intensely personal decisions are protected by the Due Process Clause. This Court in *Lawrence*, striking down Texas's criminal sodomy law,

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[36] If the intact D&E procedure were not available, the only option for women who wish to be able to hold the fetus or allow for genetic testing would be an induction abortion, which simulates labor. As set forth above, however, that procedure also is limited by the Act and, even if available, generally requires hospitalization, takes far longer, and may present greater safety risks or even be contra-indicated in certain circumstances. *See supra* note 6.

[37] *See supra* at 10-13. The *amicus* brief filed by the Institute for Reproductive Health Access and Fifty-Two Clinics and Organizations contains numerous additional descriptions of the agonizing choices women must make, and further shows the deeply personal, moral, and religious concerns, as well as medical consequences, that accompany those decisions.

confirmed the importance of individuals' due process right to be free from unwarranted governmental intrusions in their private lives in the strongest possible terms:

> Liberty protects the person from unwarranted government intrusions into a dwelling or other private places. In our tradition the State is not omnipresent in the home. And there are other spheres of our lives and existence, outside the home, where the State should not be a dominant presence. Freedom extends beyond spatial bounds. Liberty presumes an autonomy of self that includes freedom of thought, belief, expression, and certain intimate conduct.

539 U.S. at 562.

In this statement, the Court reaffirmed what earlier cases in the abortion context, including *Casey*, have established: that a vital part of liberty consists of being able to make private decisions – about relationships, about family, about reproduction, about contraception – free of government interference, so that individuals may be free to "control their destiny" by making their own decisions about how to conduct their private lives. *Id.* at 578; *accord id.* at 574 (quoting *Casey*, 505 U.S. at 857: "At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life.")

Lawrence makes plain that considerations of personal dignity and equality among all members of society are critical to determining whether a law impermissibly interferes with personal liberty. *E.g., id.* at 567 (confirming "that adults may choose to enter upon [a homosexual] relationship in the confines of their homes and their own private lives and still retain their dignity as free persons"); *id.* at 575 ("Equality of treatment and the due process right to demand respect for conduct protected by the substantive guarantee of liberty are linked in important respects, and a decision on the latter point

advances both interests.").[38] The Court described, for instance, the ways in which a criminal prohibition on same-sex sexual conduct "in and of itself is an invitation to subject homosexual persons to discrimination both in the public and in the private spheres," describing the "collateral consequences" to future employment, among other areas, from a criminal conviction. *Id.*

The Act presents similar considerations of equality and personal dignity. When a woman already facing what is often an extremely difficult decision is denied access to a medical procedure that is best able to preserve her health or comport with her deeply held personal, moral, or religious beliefs, her "dignity as a free person" is severely compromised. As discussed above, women also face substantial "collateral consequences" from the Act's ban, including potentially serious health issues and adverse effects on financial security and ability to care for family, consequences which undermine women's full and equal participation in society. The fact that the Act effectively precludes virtually all second trimester procedures leads to an even more substantial adverse effect on women's full and equal participation in society. *Casey*, 505 U.S. at 856 ("The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives.").

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38 *See generally* Pamela Karlan, *Colloquium: The Boundaries of Liberty After Lawrence v. Texas*, 102 Mich. L. Rev. 1447, 1450, 1453 (2004) ("At its core, the liberty interest at issue in *Lawrence* is the right of gay people to equal respect for their life choices"; "The real problems with prohibitions on same-sex intimacy ... come from the collateral consequences of such laws: the way in which they undergird 'discrimination both in the public and in the private spheres' and tell gay people that their choices about how to live their lives are unworthy of respect").

Lawrence also shows that restrictions on personal liberty cannot be justified solely because a governing majority believes that a particular practice is immoral. Overruling *Bowers v. Hardwick*, the Court cited Justice Stevens's dissent in that case, in which he described a proposition made "abundantly clear" by prior decisions:

> [T]he fact that the governing majority in a State has traditionally viewed a particular practice as immoral is not a sufficient reason for upholding a law prohibiting the practice; neither history nor tradition could save a law prohibiting miscegenation from constitutional attack.

539 U.S. at 577-78.

The Court confirmed (quoting *Casey*) that the obligation of the Court is to "define the liberty of all, not to mandate our own moral code." *Id.* at 571. As fully stated in *Casey*:

> Men and women of good conscience can disagree, and we suppose some always shall disagree, about the profound moral and spiritual implications of terminating a pregnancy.... Some of us as individuals find abortion offensive to our most basic principles of morality, but that cannot control our decision. Our obligation is to define the liberty of all, not to mandate our own moral code.

505 U.S. at 850. *Accord id.* at 851 (although it is "conventional constitutional doctrine that where reasonable people disagree the government can adopt one position or the other," that is not the case where the government choice "intrude[s] upon a protected liberty").

The Act does what *Lawrence*, *Casey*, and their many precedents forbid. It interferes in one of the most personal choices a woman can make based on one view of morality. *See* Act § 2(1) (claiming a "moral, medical, and

ethical consensus" for the Act). In doing so, it violates the "'promise of the Constitution that there is a realm of personal liberty into which the government may not enter.'" *Lawrence*, 539 U.S. at 578 (quoting *Casey*, 505 U.S. at 847).

Just as there is no "medical ... consensus" supporting a ban on the intact D & E procedure[39] (and even if there were, the Act still would unduly burden women's abortion rights because of its broad definition of the procedure), there is also no "moral ... and ethical consensus" behind the Act.[40] While a majority of those in Congress (over the strong opposition of others) may believe that the intact D&E procedure is inhumane and immoral, many women, including those whose tragic stories are told above, believe the opposite – that it is more humane and moral. *See supra* at 20-21. These women and their families chose an intact D&E abortion procedure based on their own intensely felt moral, and

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[39] Section I.A., the Respondents' briefs, and the *amicus* briefs submitted by ACOG and the National Abortion Federation all demonstrate that Congress' conclusion that there is "medical consensus" with respect to the intact D&E procedure is incorrect.

[40] Moreover, to the extent that the Act's proponents believe it would serve additional purposes, such as enforcing medical standards or promoting respect for life, these purposes in fact would be served only because the Act would express the legislative majority's moral opposition to the intact D&E procedure. Similar purposes were asserted for the Texas sodomy law – for example, that it would promote marriage, see, e.g., Brief of Amici Curiae Texas Legislators in Support of Respondent, 2002 U.S. Briefs 102, at 15-25 (Feb. 18, 2003) – yet the Court recognized that such purposes ultimately depended on the statute's expression of moral disapproval of homosexuality, and found them insufficient to overcome the liberty interests at stake.

sometimes religious, convictions. They thought the procedure was humane, and they wanted the opportunity to hold the fetus and grieve with their families over the lost pregnancy.

Moreover, many religious organizations believe that choosing the intact D&E procedure may be moral. As the *amicus* brief submitted on behalf of the Religious Coalition for Reproductive Choice and Thirty-Four Other Religious and Religiously Affiliated Organizations and Individual Clergy and Theologians demonstrates, many mainstream religious groups oppose the Act:

> Because protecting the health of women is a core expression of the religious values of *amici*, *amici* agree that all women whose health is at risk should be free to seek the safest medical treatment, without governmental coercion or constraint, in making the difficult decision to terminate a pregnancy. Other religious traditions and organizations also give primacy to women's health and conscience...."

Brief of *Amici Curiae* Religious Coalition for Reproductive Choice and Thirty-Four Other Religious and Religiously Affiliated Organizations and Individual Clergy and Theologians in Support of Respondents at 1-2.

In such circumstances, as *Lawrence* recognized, it is the task of the courts not to "mandate our own moral code" but to "define the liberty of all." As *Stenberg* explained, when the Court has been faced with the "virtually irreconcilable points of view" that exist in the abortion debate, it has "consider[ed] the matter in light of the Constitution's guarantees of fundamental individual liberty," and has "redetermined that the Constitution offers basic protection to the woman's right to choose." 530 U.S. at 920-21. The Constitution requires that protection be extended to women in these cases as well.

III. THE ACT UNCONSTITUTIONALLY VIOLATES WOMEN'S BODILY INTEGRITY

Another aspect of the constitutionally-protected liberty to make intensely personal decisions without governmental interference is the due process right to be free of unwarranted intrusions into one's own "bodily integrity": "It is settled now, as it was when the Court heard arguments in *Roe v. Wade*, that the Constitution places limits on a State's right to interfere with a person's most basic decisions about family and parenthood, as well as bodily integrity." *Casey*, 505 U.S. at 849 (citations omitted). It follows that women having abortions, like all individuals, have a constitutional right to choose the medical treatment they deem most appropriate for themselves. *See id.* at 857 (a woman's right to choose may be seen as a rule "of personal autonomy and bodily integrity, with doctrinal affinity to cases recognizing limits on governmental power to mandate medical treatment or to bar its rejection").

Under these principles, the Act impermissibly interferes with women's bodily integrity. It effectively denies women the right to choose abortion at all after the first trimester, because the broad and vague definition of the ban reaches virtually all second trimester procedures. And, even if the Act banned only the intact D&E procedure, it would force women to undergo a procedure that is riskier and less safe for them, may contravene the recommendation of their doctors, and may be contrary to their moral, personal, and religious beliefs. *See supra* at 7-13, 20-21. These constraints severely violate the woman's bodily integrity.

A number of analogous cases recognize that the Due Process Clause protects individuals' right to bodily integrity, and that the government may not, for instance, pump suspects' stomachs for evidence or force them to

undergo medical care they do not desire. *See Rochin*, 342 U.S. at 173-74 (it violates due process to pump a suspect's stomach for evidence); *Washington,* 494 U.S. at 221-222, 227 (the Due Process Clause provides protection against unwanted administration of antipsychotic drugs; an inmate may be given such medications against his will only if he is dangerous and a doctor determines such treatment is in his medical interest); *Cruzan v. Director, Missouri Dep't. of Health,* 497 U.S. 261, 279 (1990) (assuming that the Due Process clause guarantees a competent person the right to refuse life-saving hydration and nutrition). Surely, if a criminal suspect need not suffer the temporary discomfort of having his stomach pumped, a woman who is not accused of any crime should not have to increase her risk of uterine perforation, cervical laceration, infection, and hemorrhage.

Therefore the Act violates women's due process rights by impermissibly interfering with their ability to make their own medical and moral choices about their bodies. The government should not, and cannot, preclude women from obtaining the best and safest medical care available – and force them to jeopardize their health and their future ability to bear children, to care for themselves and their families, and to violate their own moral and religious principles.

CONCLUSION

For the reasons stated above, *amici* respectfully request that this Court affirm the decisions of the Courts of Appeals for the Eighth and Ninth Circuits.

Respectfully submitted,

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APPENDIX

THE AMICI ORGANIZATIONS

The National Women's Law Center is a non-profit legal advocacy organization that has been working since 1972 to advance and protect women's legal rights. The fundamental right to abortion recognized in Roe v. Wade is of profound importance to the lives, health, and futures of women throughout the country. Because of the tremendous significance to women of the freedom to choose whether to bear children, the National Women's Law Center seeks to preserve women's right to a safe abortion, and has filed or participated in numerous amicus briefs in this Court in cases that affect this right.

Americans for Democratic Action (ADA) is the nation's most experienced independent liberal political organization, dedicated to individual liberty and building economic and social justice at home and abroad. Since 1947, we have led public opinion and coalitions by taking early, principled stands on a broad range of issues including the reproductive rights of women everywhere.

The American Jewish Congress is an organization of American Jews founded in 1918 to protect the civil, political and religious rights of American Jews and all Americans. For almost half a century, it has opposed laws which restrict the choices of women with regard to procreation. Whether abortion or a particular abortive technique is morally acceptable is hotly debated by Americans. We neither endorse nor reject any particular resolution of that debate when we say that such contested matters are assigned by the Constitution to the individual conscience of citizens, rather than government.

The Asian American Justice Center (AAJC) is a national non-profit, non-partisan organization whose mission is to advance the legal and civil rights of Asian Americans. Collectively, AAJC and its affiliates the Asian Law Caucus, the Asian Pacific American Legal Center of Southern California, and the Asian American Institute have over 50 years experience in

providing legal public policy, advocacy, and community education on discrimination issues. The question presented by this case is of great interest to AAJC because it implicates the availability of civil rights protections for Asian Americans in this country.

California Women Lawyers (CWL) is a non-profit, umbrella organization for women's bar associations throughout the state of California. Chartered in 1974, CWL serves as a network that permits California's women attorneys, judges, law professors and law students to work together to achieve common goals, including the protection of civil rights of all individuals. CWL actively engages in the public policy debate concerning the rights of women and prepares or joins others in presenting amicus briefs in cases affecting constitutional rights, especially those that have a special impact on women.

The California Women's Law Center (CWLC) is a non-profit specializing in the civil rights of women and girls. Established in 1989, it is the first law center in California solely dedicated to addressing the comprehensive and unique legal needs of women and girls. Since its inception, CWLC has worked to ensure that all women have full and complete access to all reproductive health services, including abortions. To further this effort, CWLC recently established the Reproductive Rights Enforcement Center to collaborate with grassroots community based organizations to develop and disseminate culturally and linguistically appropriate reproductive health and rights information to diverse communities of women. CWLC has also authored numerous amicus briefs, articles, and legal education materials on abortion rights.

The Center for Women Policy Studies was founded in 1972 with a mission to shape public policy to improve women's lives. A hallmark of our work is the multiethnic feminist lens through which we view all issues affecting women and girls. In all of our work, we look at the combined impact of gender, race, ethnicity, class, age, disability, and sexual orientation. We struggle for women's human rights—justice and equality for

women on such issues as equal credit opportunity, educational equity, violence against women and girls, welfare reform, work/family balancing and workplace diversity policies, reproductive rights and health, the women's HIV/AIDS epidemic, access to health care for low-income women, and much more.

The Coalition of Labor Union Women (CLUW) is an AFL-CIO affiliate with over 20,000 members, a majority of whom are women. For more than 20 years, CLUW has advocated to strengthen the role and impact of women in every aspect of their lives. CLUW focuses on key public policy issues such as equality in educational and employment opportunities, affirmative action, pay equity, national health care, labor law reform, family and medical leave, reproductive freedom and increased participation of women in unions and in politics. Through its 75 chapters across the United States, CLUW members work to end discriminatory laws, and policies and practices adversely affecting women through a broad range of educational, political and advocacy activities. CLUW has frequently participated as amicus curiae in numerous legal cases involving issues of gender discrimination and reproductive freedom. CLUW has provided educational and training programs for many years to educate and inform workers, union leaders and employers about issues of reproductive freedom and gender equality in the workplace.

Concerned Citizens for Medical Freedom is a non-profit organization of health care and legal professionals dedicated to the concept that the limits on medicine should be determined by [illegible]nd scientific investigation and reasoning. This does not discount the importance of law and ethics. However, because modern science is always evolving, the importance of medicine having the freedom to readily adjust to new discoveries and technology is paramount.

The Connecticut Women's Education and Legal Fund (CWEALF) is a non-profit women's rights organization dedicated to empowering women, girls, and their families to achieve equal opportunities in their personal and professional

lives. CWEALF defends the rights of individuals in the courts, educational institutions, workplaces and in their private lives. Since its founding in 1973, CWEALF has provided legal information and conducted public policy and advocacy to advance women's rights. Throughout our history, we have defended women's access to full reproductive health services.

Equal Rights Advocates (ERA) is a San Francisco-based women's rights organization whose mission is to secure and protect equal rights and economic opportunities for women and girls through litigation and advocacy. Founded in 1974, ERA litigates important gender-based discrimination cases, sponsors public policy initiatives and counsels hundreds of individual women each year on their legal rights.

The Guttmacher Institute is an independent, nonprofit corporation that advances sexual and reproductive health in the United States and around the world through an interrelated program of research, policy analysis and public education. The Institute works to protect, expand and equalize access to information, services and rights that will enable women and men to avoid unplanned pregnancies, prevent and treat sexually transmitted infections, including HIV, exercise the right to choose abortion, achieve healthy pregnancies and births and have healthy, satisfying sexual relationships.

The Idaho Women's Network is a non-profit education and advocacy organization located in Boise, Idaho. Founded in 1988, and representing 28 organizational and 400 individual members, the Idaho Women's Network is the only statewide, non-partisan women's coalition in Idaho. The Idaho Women's Network serves as a voice for women and their families in the development of public policy, including women's reproductive rights.

Law Students for Choice represents over 1500 law students and lawyers who are working to increase curricula in

reproductive rights law and to augment professional training in reproductive justice work. Law Students for Choice works on a grassroots basis at law schools in both the United States and Canada, promotes activism, sponsors national and regional educational events, provides internships in reproductive rights law, maintains a website, and publishes a quarterly newsletter. Law Students for Choice is committed to educating, organizing, and supporting law students to ensure that a new generation of advocates will be prepared to protect and expand reproductive rights as basic civil and human rights.

Legal Momentum advances the rights of women and girls by using the power of the law and creating innovative public policy. Legal Momentum views reproductive rights as central to women's equality. For that reason, Legal Momentum has litigated numerous cases involving reproductive health services, including *Schenck v. Pro-Choice Network*, 519 U.S. 357 (1997), and *Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263 (1993), and has submitted amicus briefs on behalf of organizations that support women's equality in abortion cases including *Ayotte v. Planned Parenthood*, 126 S. Ct. 961 (2006), and *Stenberg v. Carhart*, 530 U.S. 914 (2000).

The Ms. Foundation for Women supports the efforts of women and girls to govern their own lives and influence the world around them. Through its leadership, expertise and financial support, the Foundation champions an equitable society by effecting change in public consciousness, law, philanthropy and social policy. Our work is guided by our vision of a just and safe world where power and possibility are not limited by gender, race, class, sexual orientation, disability or age. We believe that equity and inclusion are the cornerstones of a true democracy in which the worth and dignity of every person are valued. We founded the Reproductive Rights Coalition and Organizing Fund in 1989 to support state- and local-level organizations working on the wide range of reproductive rights issues, from abortion to contraceptive coverage to sexuality education. We believe that all women are entitled to the best possible health care.

The National Asian Pacific American Women's Forum (NAPAWF) is a membership based organization dedicated to forging a grassroots progressive movement for social and economic justice and the political empowerment of Asian Pacific American women and girls. Ensuring that all women have access to safe and timely sexual and reproductive health care services is one of the central issues that forms the basis of NAPAWF's advocacy at the national and chapter levels. NAPAWF supports policies and practices that will increase health care coverage for all women and men, educate health care providers about culturally competent and linguistically appropriate services, and ensure that all women, regardless of socioeconomic or immigrant status, have the financial ability and freedom to access the full range of sexual and reproductive health services, including abortions.

The National Center for Lesbian Rights (NCLR) is a national legal resource center with a primary commitment to advancing the rights and safety of lesbians and their families through a program of litigation, public policy advocacy, and public education. Since its inception in 1977, NCLR has had a particular interest in defending reproductive freedom for all women, regardless of sexual orientation.

The National Center for Youth Law (NCYL) is a non-profit organization located in Oakland, California. Since 1970, NCYL has worked to improve the lives of poor children nationwide. NCYL provides representation to children and adolescents in class action litigation and other cases which have broad impact. The Center also engages in legislative and administrative advocacy at the national and state levels. NCYL provides support for the advocacy efforts of others through its legal journal and training programs, and by providing technical assistance to other advocates for youth nationwide. One of NCYL's particular concerns is access to critical health care for adolescents. Beginning in 1987 and continuing for ten years, NCYL was counsel in *American Academy of Pediatrics v. Lungren*, 66 Cal. Rptr. 2d 210 (1997). In that landmark case, the

California Supreme Court determined that a legislatively-enacted requirement that minors get the permission of a parent or a judge before exercising their right to an abortion violated the California State Constitution.

The National Coalition of Abortion Providers (NCAP) is a 501(c)(4) organization founded in 1990 to provide advocacy and networking opportunities to independent abortion providers. Currently, NCAP has 150 member clinics located throughout the United States providing abortion and other reproductive health care services to women and their families.

The National Council of Women's Organizations (NCWO) is a nonpartisan, non-profit umbrella organization of over 200 groups that collectively represent some ten million women across the United States. NCWO members collaborate through substantive policy work and grassroots activism to address issues of concern to women, including women's reproductive rights and justice.

Founded in 1973, **the National Gay and Lesbian Task Force** was the first national lesbian, gay, bisexual and transgender (LGBT) civil rights and advocacy organization and remains the movement's leading voice for freedom, justice and equality. We work to build the grassroots political strength of our community by training state and local activists and leaders, working to strengthen the infrastructure of state and local allies, and organizing broad-based campaigns to build public support for complete equality for LGBT people. As part of a broader social justice movement, the Task Force works to create a world that respects and makes visible the diversity of human expression and identity where all people may fully participate in society. Headquartered in Washington, D.C., we also have offices in New York, Los Angeles, Cambridge Massachusetts, and Miami.

The National Lawyers Guild (NLG) is a national association of progressive lawyers, law students, legal workers and jailhouse lawyers. Since its founding in 1937, the Guild has

been concerned with reproductive freedom and women's rights. Most recently, the NLG has spoken out against efforts in the federal government and some states to test whether the current political climate on this Court can be exploited to undermine women's rights under settled precedent. The NLG also frequently represents activists working for reproductive rights.

The National Organization for Women Foundation is the education, litigation and advocacy arm of the National Organization for Women, the nation's largest organization of feminist activists. Since its founding in 1986, the primary mission of the NOW Foundation has been to achieve full equality for women, including bodily integrity and the right to make their own reproductive decisions, and has engaged in litigation throughout that time in support of that mission.

The National Partnership for Women & Families is a non-partisan, non-profit advocacy groups founded in 1971 that uses public education and advocacy to promote fairness in the workplace, quality health care, and policies that help women and men meet the dual demands of work and family. The National Partnership firmly believes that quality health care must include access to the full range of women's reproductive health services. As a result, the National Partnership has a long history of promoting and defending a woman's right to choose by filing amicus curiae briefs in major reproductive rights and health cases.

The Northwest Women's Law Center (Law Center) is a regional non-profit public interest organization based in Seattle, Washington, that works to advance the legal rights of all women through public impact litigation, legislation and legal rights education. Since its founding in 1978, the Law Center has been dedicated to protecting and expanding women's reproductive rights, and has long focused on the threats to women's access to safe and legal abortion. Toward that end, the Law Center has participated as counsel and as amicus curiae in cases throughout the Northwest and the country to help ensure

that women have the right to self-determination and bodily autonomy. The Law Center obtained the first injunction in the country that applied to all women's health clinics in the state and effectively stopped blockades by bringing contempt actions against blockaders who refused to obey the court's injunction. Similarly, the Law Center was a leader in successfully defeating a Washington citizen initiative that would have banned certain abortion procedures. The Law Center remains involved in legislative and litigation efforts that seek to protect women's reproductive rights, and serves as a regional expert and leading advocate for reproductive freedom.

Our Bodies Ourselves (OBOS) provides clear, evidence-based information about health, sexuality and reproduction from a feminist and consumer perspective. OBOS advocates for women's health by challenging the institutions and systems that block women's ability to obtain essential resources and support to ensure optimal health and well-being. We serve in the public interest, do not accept funds from the pharmaceutical industry, and collaborate frequently with other organizations also committed to improving the lives of women and their families.

The Sexuality Information and Education Council of the United States (SIECUS) has served as a leading national voice for sexuality education, sexual health, and sexual rights for over 40 years. SIECUS affirms that sexuality is a fundamental part of being human, one that is worthy of dignity and respect. SIECUS advocates for the right of all people to accurate information, comprehensive education about sexuality, and sexual health services.

The Southwest Women's Law Center is a non-profit public interest organization based in Albuquerque, New Mexico. Its mission is to create the opportunity for women to realize their full economic and personal potential. The Southwest Women's Law Center seeks to promote access to comprehensive reproductive health care information and services and to

eliminate discrimination and disparities in access to such services and information based on gender.

The Women's Law Center of Maryland, Inc., is a non-profit membership organization with a mission of improving and protecting the legal rights of women, particularly regarding gender discrimination, workplace issues, family law and reproductive rights. Established in 1971, the Women's Law Center achieves its mission through direct legal services, hotlines, research, policy analysis, legislative initiatives, education and implementation of innovative legal services programs to facilitate systemic change.

Founded in 1974, the **Women's Law Project (WLP)** is a non-profit feminist legal advocacy organization with offices in Philadelphia and Pittsburgh, Pennsylvania. WLP works to advance the legal and economic status of women and their families through litigation, public policy development, education, and one-on-one counseling. Throughout the past thirty-two years, WLP has played a leading role in the struggle to protect women's reproductive liberty and autonomy. WLP has represented reproductive health care providers and/or their patients before this Court in *Ferguson v. City of Charleston*, 532 U.S. 67 (2001); *Planned Parenthood v. Casey*, 505 U.S. 833 (1992); and *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747 (1986).

WOMENS WAY is the nation's oldest and largest women's funding federation. Founded in 1977, WOMENS WAY's proud mission is to fight for and achieve women's equality, safety, self-sufficiency, and reproductive freedom through women-centered funding, advocacy and education.

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IN THE

Supreme Court of the United States

ALBERTO R. GONZALES, Attorney General,

Petitioner,

—v.—

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., *et al.*,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

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QUESTIONS PRESENTED

Whether the Partial Birth Abortion Ban Act of 2003, Pub. L. No. 108-105, 117 Stat. 1201 (2003) (the "Act"), is unconstitutional, even if construed as banning only intact dilation and evacuation ("D&E") abortions, because banning such abortions would deprive some women of a meaningfully safer pre-viability abortion option, and would thus endanger women's health.

Whether the Act is unconstitutional because it either will chill physicians from performing any D&E (the most commonly used pre-viability second-trimester abortion method), or will force physicians to alter their medical practices to avoid felony prosecution, even if it means acting against their best medical judgment, and therefore imposes an undue burden on a woman's right to end a pre-viability pregnancy.

Whether the Act is unconstitutionally vague because it fails to provide fair warning of the medical procedures it bans, and permits arbitrary and discriminatory enforcement.

PARTIES TO THE PROCEEDING

Petitioner is Alberto R. Gonzales, Attorney General of the United States.

Respondents are Planned Parenthood Federation of America, Inc.; Planned Parenthood Golden Gate; and the City and County of San Francisco.

Respondents Planned Parenthood Federation of America, Inc. and Planned Parenthood Golden Gate are not-for-profit corporations that do not have parent corporations and are not owned in any part by a publicly held company.

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STATEMENT OF THE CASE[1]

Congress enacted the Partial-Birth Abortion Ban Act of 2003, Pub. L. No. 108-105, 117 Stat. 1201 (2003) (the "Act"), in an effort to nullify this Court's decision in *Stenberg v. Carhart*, 530 U.S. 914 (2000).[2] Petitioner (the "Government") argues that the Act should be upheld because it differs from the Nebraska law invalidated in *Stenberg* in two respects: first, it is accompanied by congressional findings that are entitled to deference; and, second, it describes the criminalized medical procedures differently. Alternatively, the Government argues that *Stenberg* should be overruled.

Not only are the Government's distinctions meritless, but its argument obscures the real difference between this appeal and *Stenberg*. This appeal comes to this Court on a record developed during a three-week trial, including testimony from an array of distinguished physicians associated with major medical institutions nationwide. On the basis of that record, the District Court made extensive findings of fact regarding the significant medical benefits and safety of intact dilation and evacuation ("intact D&E") abortions,[3] and the indefensibility – under any standard of

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[1] References to PA are to the Appendix to the Petition for A Writ of Certiorari; references to JA are to the Joint Appendix; references to Gov't Br. are to the Brief for the Petitioner; references to ER are to the Ninth Circuit Excerpts of Record; references to Supp. ER are to the Ninth Circuit Supplemental Excerpts of Record; references to Carhart Gov't Br. are to the Brief for the Petitioner in *Gonzales v. Carhart*, No. 05-380.

[2] *See, e.g.*, 149 Cong. Rec. S3486 (daily ed. Mar. 11, 2003) (statement of Sen. Santorum) ("Why are we here? We are here because the Supreme Court defended the indefensible. . . . We have responded to the Supreme Court."); 149 Cong. Rec. S3606 (daily ed. March 12, 2003) (statement of Sen. Santorum) ("What the Supreme Court did . . . is fundamentally wrong.").

[3] While the Act does not mention intact D&E or D&X (or, indeed, use the word "intact"), the Government states that "partial-birth abortion" refers to intact D&E, or D&X, the term used in *Stenberg*. Gov't Br. 2. The Ninth Circuit correctly held that the terms intact D&E and D&X are interchangeable. PA 3a-4a n.3; *see also Stenberg*, 530 U.S. at 928.

review – of the congressional findings. The lengthy trial debunked numerous myths and misperceptions about intact D&Es that were propagated by Congress, codified in the Act's findings, and repeated by the Government throughout this litigation. The record here establishes that:

- The terms "*infant*icide," "partial-*birth*" abortion, and "late-term" abortion (*e.g.*, Gov't Br. 2, 9, 47) (emphasis added) are blatantly misleading. Intact D&E is used predominantly in the second trimester – or "mid-term" – of pregnancy. PA 83a, 84a; *see also* JA 1103. And only pre-viability abortions are at issue because Planned Parenthood's health centers perform no post-viability abortions. Trial Tr. 135:16-18, Mar. 29, 2004; *cf.* PA 83a.
- Although the Government and Congress claim the Act bans only one particular method of abortion, intact D&E (*e.g.*, Gov't Br. 2), the lower courts found that the Act also bans some non-intact (disarticulation) D&Es. PA 80a-84a, 32a; Gov't Br. 34 n.6. Collectively, D&Es account for 95% of pre-viability, second-trimester abortions. PA 58a.
- Claims that the health benefits of intact D&E are "marginal[]" and that intact D&E is "never medically indicated" (Gov't Br. 21, 24; Act § 2(14(O)), are refuted by the record. Leading obstetrician-gynecologists – including an expert panel assembled by the American College of Obstetricians & Gynecologists ("ACOG") – identified a range of specific medical circumstances in which intact D&E has meaningful safety advantages over other methods. *See* § I.B.1.b, *infra*; JA 855, 860-61, 1104.
- Contradicting Congress's finding that intact D&E is a "disfavored [medical] procedure" (Act § 2(2)), many major medical organizations believe that intact D&E carries meaningful safety advantages over other methods. Supp. ER 485-87 (ACOG), ER 553 (Cal. Med. Ass'n)

("CMA"), 562 (Am. Pub. Health Ass'n) ("APHA"); *see generally* PA 186a; *cf.* JA 670; PA 106a (Am. Med. Ass'n) ("AMA"). No comparable medical organizations supported the Act.

- Congress's finding that "no medical schools" teach intact D&E (Act § 2(14)(B)) is verifiably false. Intact D&E is taught at leading medical schools such as those at Columbia University, Cornell University, New York University, Northwestern University, University of Pittsburgh, University of California at San Francisco, and Albert Einstein College of Medicine, and will likely be taught at Yale University. PA 205a; *Nat'l Abortion Fed'n v. Ashcroft*, 330 F. Supp. 2d 436, 479 (S.D.N.Y. 2004), *aff'd*, *Nat'l Abortion Fed'n v. Gonzales*, 437 F.3d 278 (2d Cir. 2006) ("*NAF*"). Intact D&Es are also performed and taught at other leading medical schools that do not want to be publicly identified. *See* JA 1100, 1101, 1107-08.
- Contrary to Congress's and the Government's core rationale for the Act, there is no moral or ethical consensus about intact D&E. There are significant moral and ethical concerns on both sides, including the ethics of denying women access to the safest treatment and forcing doctors to use medical techniques they consider less safe. *See* JA 537 ("[T]he only reason why I want to be able to . . . perform a D&E with intact extraction . . . is because . . . that is the best way I can take care of my patients."); *see also* JA 187 ("I wouldn't even have any idea how to consent a patient if I am [doing something to avoid liability, and not] for her clinical benefit.").

Congressional History

The Government recounts that Congress held hearings leading to the Act's passage, but fails to note both the partisan and polemic nature of the hearings, and the fact

that they elicited no medical information that meaningfully differed from the evidence before this Court in *Stenberg*.

Between 1995 and 2003, Congress held six hearings about so-called "partial-birth abortion."[4] PA 173a. In all, only eight physicians testified – six supporting the ban.[5] The District Court concluded that the oral testimony before Congress was "not only unbalanced, but intentionally polemic," and was "heavily weighted in favor of the Act," with Congress hearing "disproportionately from physicians opposed to abortion generally." PA 183a, 182a; *see also Carhart v. Ashcroft*, 331 F. Supp. 2d 805, 822 (D. Neb. 2004) (the congressional record "contains remarkably little substantive information from physicians on either side"); *id.* at 1011 ("Congress arbitrarily relied upon the opinions of doctors who claimed to have no (or very little) recent and relevant experience with surgical abortions.").

Following *Stenberg*, new "partial-birth abortion" legislation was introduced. The post-*Stenberg* bills were *designed* to serve as vehicles for overturning *Stenberg* by omitting the health exception that this Court held was required, and "finding" that one is not needed. *See* PA 42a n.26 (citing 149 Cong. Rec. H4933 (daily ed. June 4, 2003) (statement of Rep. Conyers) ("The 'findings,' in effect, are an attempt to overturn *Stenberg*.")); 149 Cong. Rec. H4933 (daily ed. June 4, 2003) (statement of Rep. Farr) ("[T]his legislation presumes that the authors' findings overrule those of the Supreme Court.").[6]

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[4] This Court is familiar with the four Congressional hearings held prior to *Stenberg*. *See, e.g.*, 530 U.S. at 929, 935.

[5] This excludes doctors who testified solely about the effect of maternal anaesthesia on a fetus. PA 177a.

[6] The findings that were enacted into law in 2003 were identical to the 2002 bill findings. The findings did not take into account post-*Stenberg* evidence. Rather, they were prepared and made part of the first

Congress held two cursory post-*Stenberg* hearings. It heard from only two doctors who had not previously testified, and both supported the ban. *See* PA 173a-82a. As the lower courts noted, and belying Congress's claim that much of Congress's evidence was compiled post-*Stenberg* (Act § 2(5)), none of the post-*Stenberg* testimony provided new information. *See* PA 193a ("Congress did not have before it any *new* medical evidence or studies not available to both the district court and Supreme Court in *Stenberg*.") (emphasis in original); *NAF v. Gonzales*, 437 F.2d at 292 n.9 (Walker, C.J., concurring) ("[T]he evidence has not changed since the Supreme Court decided *Stenberg* – only the conclusions that Congress decided to draw from that evidence"); *accord* PA 192a.

In 2003, during the 108th Congress which enacted the Act, highly-credentialed physicians and nationally recognized major medical groups, including ACOG, submitted statements to Congress opposing the Act. 149 Cong. Rec. S3479 (daily ed. Mar. 11, 2003) (statement of Sen. Boxer) (ACOG); Supp. ER 521 (Am. Med. Women's Ass'n) ("AMWA"), 554-55 (Ass'n of Reprod. Health Professionals) ("ARHP"), 562 (APHA); *see generally* PA 186a.[7] No comparable medical groups supported the ban. Supp. ER 670-76 (medical submissions in Congress post-*Stenberg*).

Congressional proponents, however, ignored the substantial medical opposition to the bill, ignored the evidence of the medical benefits of intact D&E, and ignored Congressional colleagues who repeatedly advised that the

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post-*Stenberg* bill before Congress held a single post-*Stenberg* hearing. *See NAF*, 437 F.3d at 292 n. 9 (Walker, J., concurring) (citations omitted).

[7] The AMA, which had supported earlier bans, opposed the Act because of its criminal penalties. Supp. ER 556. A consulting firm hired by the AMA to review its decision-making processes concluded that its support for pre-*Stenberg* versions came out of the "least democratic, least researched, and least systematic decision-making process." ER 1123.

bill was unconstitutional. Congress rejected amendments that would have added a health exception, stricken the inaccurate congressional findings, and limited the Act's applicability to post-viability abortions. PA 80a-81a, 87a, 189a-90a, 193a-94a n.50, 207a-08a.

Lower Court Proceedings

During the three-week bench trial, twelve expert obstetrician-gynecologists ("ob-gyns") appeared in person to testify for both sides. The District Court also accepted into evidence deposition testimony from an additional five expert ob-gyns, an expert pathologist, designated representatives of ACOG and three other medical groups, and two Department of Justice officials. The District Court concluded that it "was presented with much more extensive medical and scientific evidence on both sides of the issue concerning the safety and necessity of intact D&Es" than Congress, which "heard significantly more policy-based arguments." PA 172a; *cf. NAF*, 330 F. Supp. 2d at 482 (New York district court heard "more evidence during its trial than Congress heard over the span of eight years").

Eight of Planned Parenthood's eleven expert ob-gyns testified in person. Each of the eight is board-certified in ob-gyn, three were also qualified as experts in maternal-fetal medicine, and two as experts in epidemiology. These eight are experts in second-trimester surgical abortion care; all are affiliated with major teaching hospitals; and all have taught and performed intact D&Es, as well as other safe abortion procedures. PA 97a-99a & n.16 (describing qualifications). In contrast, none of the Government's witnesses has expertise in second-trimester surgical abortion care; and none has taught, performed or even personally observed

intact D&E. PA 100a-04a.[8]

Critical to the District Court's ruling were its determinations about expertise and credibility. The District Court qualified Planned Parenthood's eight in-person ob-gyn witnesses as experts in intact D&E, as well as in ob-gyn generally, and found their testimony credible. PA 139a, 144a ("These doctors are all well-respected in their practices, and their expertise in recommending and performing D&E and intact D&Es is unassailable.").

The Government's four in-person ob-gyn witnesses were qualified as experts in ob-gyn generally. However, the District Court found they "lacked the background, experience, and instruction to qualify as experts regarding" intact D&E because none had ever been instructed regarding, or had ever performed, supervised, taught, been taught, or even observed an intact D&E procedure.[9] PA 104a. Indeed, the Government's in-person ob-gyn witnesses had minimal experience performing *any* D&E procedures. PA 101a-04a.

In addition, the District Court had "credibility concerns" about two Government witnesses, Drs. Sprang and Cook. PA 185a; *see also* PA 140a-41a; *Carhart*, 330 F. Supp. 2d at 1024. These witnesses were connected to the proceedings in Congress. Dr. Sprang co-authored "an opinion piece," M. Leroy Sprang & Mark G. Neerhof, *Rationale for Banning Abortions Late in Pregnancy*, 280 J. Am.

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[8] Government expert Charles Lockwood was the Chair of the Ob-Gyn Department at NYU when intact D&Es were taught and performed there by physicians he hired. JA 995-96.

[9] The District Court allowed the Government's ob-gyn witnesses "to testify only regarding their opinions on the safety of [intact D&E], based upon their review of the literature" because they "did not 'appear to have any personal experience with'" relevant abortion procedures. PA 104a.

Med. Ass'n 744 (1998) ("Sprang article"), ER 896-99, "upon which Congress very obviously relied" in preparing its findings. PA 184a.[10] The District Court found that "a number of the conclusions" in the Sprang article are "troublesome and contrary to the medical evidence presented by both sides to this court," and that given the "contradictory testimony that Dr. Sprang gave at trial, the article and many of its conclusions become even more questionable." PA 184a-85a. Dr. Cook appeared twice before Congress and testified that there was no need for intact D&E in the cases of particular women who had testified about the intact D&E abortions they had, but he "did not explain the medical reasons for his conclusions." PA 179a. At trial, Dr. Cook acknowledged that he did not review the actual medical records associated with the cases about which he testified before Congress. JA 769-70.

On the basis of its detailed fact-finding, the District Court struck down the Act on the grounds that:

(a) the Act is unconstitutional for lack of a health exception because "the record before this court . . . demonstrates that 'significant medical authority supports the proposition that in some circumstances, [intact D&E] is the safest procedure'" (PA 214a (citation omitted)), and the congressional findings do not trump the need for a health exception because they are "unreasonable and . . . not supported by substantial evidence" (PA 212a);

(b) the Act imposes an undue burden on a woman's right to abortion because the Act's definition of "partial-birth abortion" encompasses all variants of D&E, the

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[10] Dr. Sprang did not testify before Congress, but his co-author, Dr. Neerhof, testified for the ban during the 108th Congress. ER 862-66.

method used in 95% of all pre-viability, second-trimester abortions (PA 85a-89a); and

(c) the Act violates physicians' due process rights by failing to give them adequate notice of which abortions are banned and which are permitted, and placing them at risk of arbitrary and discriminatory enforcement (PA 92a-96a).

The Ninth Circuit affirmed on these same grounds and permanently enjoined the Act in its entirety after analyzing the remedy question under the framework this Court set forth in *Ayotte v. Planned Parenthood of Northern New England*, 126 S. Ct. 961 (2006).

SUMMARY OF ARGUMENT

This appeal reaches this Court with a factual record compiled after a lengthy trial including testimony from numerous highly-credentialed and respected medical experts with expertise in second-trimester surgical abortions, and a District Court ruling containing detailed findings of fact that are overwhelmingly supported by the evidence. Those facts demonstrate, as even some Government witnesses agreed, that any D&E abortion when performed in the safest manner can proceed so as to meet each of the statutory elements of a "partial-birth abortion." Thus, the Act is unconstitutional because physicians will either be chilled from continuing to provide these procedures, or they will be forced sometimes to alter their practices to avoid criminal prosecution – even if it means proceeding against their best medical judgment. In either event, women's liberty will be infringed and their right to choose abortion unduly burdened.

Alternatively, if the terms of the Act do not put physicians at risk each time they perform a D&E (in other words, if the Act does not mean what it says), then it fails to

provide physicians with fair warning as to which abortions are permitted, and which are federal felonies; and is, thus, unconstitutionally vague.

The Government has offered various interpretations of the Act in an effort to escape these failings. These interpretations are inconsistent with each other, unsupported by any fair reading of the Act, and draw insupportable distinctions among medical procedures. Thus, the Government's efforts highlight, rather than solve, the Act's constitutional defects.

The record also demonstrates beyond cavil that there are numerous circumstances where women suffering from serious medical conditions or carrying fetuses with severe anomalies would derive meaningful medical benefits from intact D&E, and that even for women whose health condition is not compromised, intact D&E is a significantly safer method of abortion. The record lays to rest the Government's assertion that the medical benefits of intact D&E are marginal, hypothetical, or affect only a few women. Therefore, the Act is also unconstitutional because it purposefully lacks an exception to allow the banned procedures whenever necessary to protect a woman from a significant health risk.

The congressional findings do not alter this conclusion. The findings are an effort to circumvent this Court's authority to determine the scope of individual rights, relating to the longstanding constitutional protection for women's health in the context of abortion regulations, and thus are due little deference. In any event, as the lower courts concluded, under *any* standard of review, the congressional findings are entitled to no deference because they are patently unreasonable.

The Government urges that *Stenberg v. Carhart* be

overruled. Not only does this Court's jurisprudence not recognize any reason for doing so, but overturning *Stenberg* would implicate the consistent line of precedent that pregnant women cannot be forced to sacrifice or compromise their health by an abortion regulation. The Court has never recognized a state interest strong enough to trump the paramount concern that pregnant women's health be safeguarded, and it should not do so here.

The Government addresses these issues in the reverse order. Although Planned Parenthood believes the Court need not reach the health exception claim because the Act could ban any D&E, we have presented our arguments below in the same order as in the Government's Brief.

ARGUMENT

I. THE ACT UNCONSTITUTIONALLY IMPERILS THE HEALTH OF SOME PREGNANT WOMEN

In an unbroken line of cases beginning with *Roe v. Wade*, 410 U.S. 113 (1973), and reconfirmed unanimously in *Ayotte*, this Court has ruled that the government cannot regulate abortion in a manner that imperils women's health. The Government now asks the Court to reject its precedents and rule that – even before fetal viability, when the state interest in regulating abortion is less compelling (*Stenberg*, 530 U.S. at 930) – a governmental preference for how fetal demise occurs justifies forcing some women to end their pregnancies by abortion procedures that leading ob-gyns and ACOG believe are significantly less safe. This Court should decline this request, reaffirm *Stenberg* and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), and affirm the lower court.

A. The Court Should Apply the "Substantial Medical Authority" Test

This Court has repeatedly made clear that abortion

regulations that do not protect women's health are unconstitutional. Thus, in *Roe v. Wade*, the Court recognized the state's authority to ban post-viability abortions, but only if abortions to protect women's health are excepted. 410 U.S. at 164-65. In *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52 (1976), this Court struck down a ban on saline amniocentesis abortions because it "force[d] a woman . . . to terminate her pregnancy by methods more dangerous to her health." *Id.* at 79. In *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747 (1986), the Court struck down a requirement that a second physician be present for post-viability abortions because it lacked an exception for when delay in arrival of the second physician would endanger the woman. Thus, even in the context of post-viability abortions where governmental interests are most compelling, abortion regulations cannot "fail[] to require that maternal health be the physician's paramount consideration." *Id.* at 768-69. Citing *Roe*, *Danforth* and *Thornburgh*, the Court unanimously reaffirmed the ongoing vitality of this principle last term in *Ayotte*. 126 S. Ct. at 967.

In applying this principle in *Casey*, the Court considered it crucial that the medical emergency exception was broad enough "'to assure that compliance with [the challenged restrictions] would not in any way pose a significant threat to the life or health of a woman.'" 505 U.S. at 880 (citation omitted). Otherwise, the Court "would be required to invalidate the restrictive operation of the provision." *Id.* *Stenberg* applied this aspect of *Casey*. It ruled that to prevent a "significant threat to the life or health of a woman," *id.*, a method-specific ban must have a health exception if "substantial medical authority supports the proposition that banning [that method] could endanger women's health." *Stenberg*, 530 U.S. at 938; *see also id.* at 947 (O'Connor, J., concurring) ("[T]he Nebraska statute is inconsistent with *Casey* because it lacks an exception for

those instances when the banned procedure is necessary to preserve the health of the mother.").

Requiring "substantial medical authority" as the quantum of proof for whether a health exception is constitutionally required to prevent a "significant threat to the life or health of a woman," *Casey*, 505 U.S. at 880, ensures both that individual physicians cannot act with "unfettered discretion," *Stenberg*, 530 U.S. at 969 (Kennedy, J., dissenting), and that "responsible differences of medical opinion" are "tolerate[d]." *Id.* at 937. Moreover, the substantial medical authority test strikes the correct balance because it incorporates the principle – integral to safeguarding a constitutionally protected liberty interest – that if an error is to be made, it should be on the side of protecting pregnant women's health and liberty, especially pre-viability, when the governmental interests on the other side are simply insufficient to place women at "risk of tragic health consequences." *Id.* at 937.

The Government does not address the "substantial medical authority" standard. Rather, it argues that the lack of a health exception is facially constitutional so long as "significant health risks" are not imposed on "a large fraction" of women.[11] *E.g.*, Gov't Br. 13, 18. Under this chillingly callous view, *some* fraction of pregnant women – so long as it is not a "large fraction" – could be forced to endure "significant health risks" before a pre-viability abortion restriction could be found unconstitutional. This is

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[11] The Government places great emphasis on the risks being "significant," Gov't Br. 14, but there can be no dispute that the health risks at issue here rise to that level: the District Court found and the evidence demonstrates that intact D&E is "significantly" safer for some women than other methods, *see* § I.B.1, *infra*; *cf. Thornburgh*, 476 U.S. at 807 (White, J., dissenting) (the term "significant" in this context means that the comparative safety benefits are meaningful, cognizable, appreciable, and non-negligible).

neither the law nor constitutionally tolerable. Allowing a measurable but not "large fraction" of pregnant women to suffer significant harm before an abortion restriction is invalidated – *at least* as to the affected women – would contravene *Roe*'s "essential holding" that the health of pregnant women must remain paramount when regulating abortion. *Casey*, 505 U.S. at 880;[12] *accord Stenberg*, 530 U.S. at 934 ("relative rarity" of intact D&Es "not highly relevant" because "question is whether protecting women's health requires an exception for those infrequent occasions"); *Ayotte*, 121 S. Ct. at 267 (medical emergency exception needed in only a "very small percentage of cases").[13]

For these reasons, the abortion ban here must contain a health exception if "substantial medical authority supports the proposition that banning [intact D&E] could endanger women's health." *Stenberg*, 530 U.S. at 938.

B. "Substantial Medical Authority" Supports the Need for a Health Exception Here

The record overwhelmingly shows that intact D&E reduces the risks of potentially catastrophic complications, and thus its health benefits are not, as the Government cavalierly argues, "marginal." *E.g.*, Gov't Br. 10, 27-29. Because the quantum of evidence rises to the level of "substantial medical authority," the Act must have a health exception. 530 U.S. at 938.

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[12] In *Casey*, no party contended that, nor did the Court inquire whether, preeclampsia (or the other conditions at issue) affects a "large fraction" of pregnant women. Yet, if the medical emergency exception did not encompass those conditions, it would have been unconstitutionally narrow. 505 U.S. at 880.

[13] The "large fraction" inquiry relates to remedy; it does not relate to constitutional adequacy. *See generally* Br. for Am. Civil Liberties Union, N.Y. Civil Liberties Union, & Nat'l Abortion Fed'n as *Amici Curiae* Supporting Respondents.

1. Intact D&E is Significantly Safer

The District Court found that "intact D&E is in fact the safest medical option for some women in some circumstances and is significantly safer than induction, hysterotomy, or hysterectomy for terminating a second-trimester pregnancy, and under certain circumstances, also significantly safer than D&E by disarticulation."[14] PA 147a; *see also* PA 144a, 215a. It further found that there "appears to be little risk from the various elements of an intact D & E procedure." PA 145a. These factual findings are subject to a "clearly erroneous" standard of review. Fed. R. Civ. P. 52(a). Indeed, because they are based in part on the "credibility concerns" regarding two of the Government's four in-person ob-gyn witnesses (PA 185a; *see also* PA 140a-41a), they are entitled to especially great deference. *Anderson v. City of Bessemer City*, 470 U.S. 564, 574-75 (1985) (fact-finding based on credibility "can virtually never be clear error").[15]

The District Court, which is charged with resolving factual disputes, heard the testimony of twelve ob-gyns who testified in person, and chose to "accept[] the[] testimony [of the Planned Parenthood experts] over that of the government witnesses, who, while also well-respected and qualified to provide testimony in general on ob-gyn practice

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[14] These methods are discussed in § II.A.2.a, *infra*.

[15] Even if the findings that intact D&E is "significantly safer" and poses "little risk" were mixed questions of law and fact, or constitutional facts, they still must be reviewed deferentially because they are based on witness credibility. *See Salve Regina College v. Russell*, 499 U.S. 225, 233 (1991), citing *Miller v. Fenton*, 474 U.S. 104, 114 (1985) (even where unclear if a conclusion is "law" or "fact," there are "compelling and familiar justifications" for giving presumptive weight to trial court credibility determinations); *cf. Harte-Hanks Communications, Inc. v. Connaughton*, 491 U.S. 657, 688-89 & n.35 (1989) (even where appellate court engages in independent review of facts to determine if constitutional standard has been satisfied, credibility determinations are reviewed under clearly erroneous standard).

and safety, do not perform intact D&Es and who were not qualified to testify as experts on the practice." PA 144a.

The Government criticizes this decision (Gov't Br. 26), but given the broad discretion of a district court to choose which witnesses to qualify as expert and which to credit, and the reasonableness of the District Court's decision, their arguments fall flat. *See, e.g., United States v. Allegheny Ludlum Corp.*, 366 F.3d 164, 186 (3d Cir. 2004) (citing *Gen. Elec. Co. v. Joiner*, 522 U.S. 136, 142 (1997)). Because the Government witnesses were inexperienced in *any* method of second-trimester surgical abortion, it was appropriate for the District Court to conclude that they could not meaningfully compare the risks and benefits of those techniques based on personal experience. Likewise, it was appropriate for the District Court to conclude that because the Government witnesses' only basis for understanding how an intact D&E is performed was based on hearsay, their assessment of the risks of the procedure could not be fully reliable.[16] For example, because they had no experience with the intact D&E technique, the Government witnesses were concerned about maternal harm due to "blind instrumentation" to reduce the fetal skull. But Planned Parenthood's experts explained, based on their clinical experience, that this concern was unfounded because this part of the procedure is performed under direct or ultrasonic visualization.[17] PA 68a.

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[16] *See, e.g.*, PA 101a n.18 (Dr. Sprang testified that his understanding was based in part on "significant" or "memorable" conversations with physicians, but he could not remember their names, or the dates or locations of those conversations), 102a n.19 (videotape that Dr. Cook reviewed of intact D&E was of "extremely poor" quality).

[17] It was also appropriate for the District Court to discount the testimony of at least some of the Government's witnesses because they were biased against all abortions, or – at a minimum – against all forms of D&E. PA 139a, 195a n.51, 199a; *cf.* PA 140a. That such physicians oppose

As shown below, the District Court's fact-finding is well-supported by the trial and congressional records, especially in light of its expertise and credibility findings, and is certainly not "clear error." Given the overwhelming evidentiary support, as found at trial and affirmed by the appellate court, the District Court's factual findings should not be disturbed. *Easley v. Cromartie*, 532 U.S. 234, 242 (2001) ("Where an intermediate court reviews, and affirms, a trial court's factual findings, this Court will not 'lightly overturn' the concurrent findings of the two lower courts.").

a. The Record Proves That Intact D&E is "Significantly Safer" Than Other Methods and Poses Little Risk

i. Planned Parenthood's experts testified that in their clinical judgment, based on substantial experience performing D&Es by all variants, D&Es in which the fetus is evacuated intact or relatively intact reduce the risk of serious complications and thus are significantly safer. The reduction in risk occurs because in intact D&Es: (1) Fewer passes are made through the woman's cervix and into her uterus with forceps and other instruments, resulting in reduced risk of lacerations to the cervix and uterus, reduced risk of uterine perforation, and reduced risk of infection.[18] (2) There is a reduced risk of leaving fetal parts in the uterus, which can cause infection. (3) There is a reduced risk of lacerations to the woman caused by the removal of sharp, bony fetal fragments. (4) There may be a reduced operating time, which likewise decreases the risks associated with blood loss and infection. It may also reduce the need for anesthesia, which in turn reduces the risks of the woman

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intact D&E does not prove that it is unsafe or inappropriate.

[18] Several Planned Parenthood experts have inadvertently injured a woman's uterus or cervix during a disarticulation D&E, but have never done so during an intact D&E. JA 77, 133, 283-84, 500, 966-67.

vomiting and aspirating her stomach contents. PA 144a; *see also* JA 116-19, 221, 424-27, 499-501, 923-24.

The substantial experience and expertise of the physicians who testified to the meaningful safety benefits of intact D&E cannot be denied. *See* PA 98a n.16; JA 14-21, 102-15, 154-69, 92-202, 244-56, 339-49, 416-23, 464-76.[19]

ii. Several Government experts acknowledged the benefits of intact extraction versus disarticulation, primarily because reduced instrumentation in the woman's uterus lowers the risks of cervical and uterine trauma, including perforation, and lowers the infection risk. JA 570-71, 720, 727, 780-81, 999-1000.

iii. Many medical organizations agree that intact D&E reduces the risks for some patients. For example, an AMA task force on which Defendant's expert Dr. Sprang served ("AMA Task Force"), concluded that: "[Intact D&E]

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[19] Although ignored in the congressional findings, many highly qualified physicians submitted letters to Congress describing medical benefits of intact D&E similar to the benefits described at trial. These submissions were from: (a) ob-gyns who regularly perform intact D&E (*see, e.g.*, Supp. ER 572 (letter from William K. Rashbaum, M.D., Professor of Obstetrics & Gynecology, the Albert Einstein Coll. of Med. and the Cornell Sch. of Med.)); (b) ob-gyns who refer patients to other physicians for intact D&Es because of the special advantages of this procedure (*see, e.g.*, 142 Cong. Rec. S11352 (daily ed. Sept. 26, 1996) (statement of Sen. Boxer) (letter from Dru Elaine Carlson, M.D., Dir., Reprod. Genetics, Dep't of Obstetrics & Gynecology, Cedars-Sinai Med. Ctr., and Assistant Professor, UCLA Sch. of Med.); Supp. ER 567-69 (letter from Laurence Burd, M.D., Assoc. Professor of Clinical Obstetrics & Gynecology, Univ. of Ill.) submitted to the Cong. Rec., Dec. 4, 1995 (141 Cong. Rec. S17891)); and (c) ob-gyns who perform and/or are familiar with the performance of abortions (*see, e.g.*, Supp ER 573-76 (letter from Natalie Roche, M.D., Assistant Professor of Obstetrics & Gynecology, N.J. Med. Coll., & Gerson Weiss, M.D., Professor & Chair, Dep't of Obstetrics, Gynecology & Women's Health, N.J. Med. Coll.) submitted to the Cong. Rec., Mar. 10, 2003 (149 Cong. Rec. S3385)).

may minimize trauma to the woman's uterus, cervix, and other vital organs. Intact D&[E] may be preferred by some physicians, [p]articularly when the fetus has been diagnosed with hydrocephaly or other anomalies incompatible with life outside the womb." JA 670; *accord* PA 106a; *see also* Supp. ER 485-87 (ACOG), 552-53 (CMA), 554-55 (ARHP), 562 (APHA); ER 1057 (AMWA),; *see generally* PA 186a.

iv. "[P]reliminary results" of the only peer-reviewed study of intact D&E "indicate the relative safety of intact D&E, and provide valuable information for doctors in exercising their clinical judgment." PA 143a; *see* JA 1055 (Stephen T. Chasen, *et al., Dilation and evacuation at ≥ 20 weeks: comparison of operative techniques*, 190 Am. J. Obstetrics & Gynecology 1180 (2004) ("Chasen study")). The Chasen study compared complications of intact D&Es at a median gestational age of twenty-three weeks with complications of disarticulation D&Es at a median gestational age of twenty-one weeks, and found the two techniques to be equally safe at those respective gestational ages. However, because the risks of abortion increase with gestational age, one would have expected more complications in the intact D&E group. JA 430-32. This suggests that intact D&Es are safer than disarticulation D&Es when performed at the same gestational age. JA 430-32, 492-93, 497-99. Notably, the only serious complications in the Chasen study were experienced by women who had disarticulation D&Es. JA 432, 491-92.

v. Experts on both sides agreed that the hypothesized risks of intact D&E are overstated or speculative. Government witness Dr. Bowes testified that intact D&E does not pose long-term maternal health risks, and does not pose risks on a more serious or frequent basis than other abortion methods. JA 587-88. Government witness Dr. Clark does not believe that intact D&E carries "increase[d] . . . risks compared to D&E or any other method

of termination." JA 901. Government witness Dr. Lockwood testified that the congressional findings "exaggerate the risk of the procedure," and that there is no greater risk of amniotic fluid embolism as between disarticulation and intact D&Es. JA 990, 1034. Government witness Dr. Sprang agreed with the AMA Task Force that "there is little research on whether [cervical incompetence is] more likely to result from D&E (or intact D&X) or from labor induction techniques." JA 671-72; *see also* PA 145a (Government failed to prove that intact D&E increases likelihood of cervical incompetence).

b. The Safety Benefits of Intact D&E are Particularly Important for Some Women

The record also amply supports the District Court's finding that intact D&E has particular benefits for "some women in some circumstances." PA 147a. ACOG's select panel of experts considered "at a minimum, 25 to 30 different types of cases" where intact D&E was used, and concluded that there were individual patient circumstances when it was a better choice for the patient. JA 1108-09; *see also* JA 1104-05. Intact D&E offers particular benefits where: (i) it is especially important to minimize instrumentation in the uterus; (ii) it is especially important to minimize blood loss; (iii) the pregnancy involves an abnormal placenta; (iv) the fetus suffers from a severe anomaly resulting in an enlarged body part; and (v) it is especially important to minimize any complication.[20]

i. ACOG's select panel identified several circumstances where intact D&E was significantly safer due to reduced uterine instrumentation, including:

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[20] Intact D&E is sometimes sought to facilitate pathological testing or the grieving process. *See* JA 296-97, 427-28, 501-02, 924-25.

- where the abortion is to treat sepsis (a severe systemic infection) because "any increase in instrumentation might increase the ability of bacteria to enter the bloodstream." JA 860-61, 1110; *see also* Supp. ER 565-66.
- where the woman suffers from trophoblastic disease (potentially malignant uterine tumors developing from abnormal proliferation of placental cells) because "increased instrumentation is likely to transport [the] disease . . . to other areas such as the lung." JA 861, 1110.

ii. Several physicians testified that intact D&E minimizes the risk of particularly dangerous complications for women prone to hemorrhage, *see, e.g.*, JA 506-07, 919-20 (anemic women; women on chemotherapy; women with acute fatty liver of pregnancy), or women who need to reduce the risk of bleeding. *See* JA 374-76 (women taking anti-coagulants; women with liver failure or who recently had liver transplants); 143 Cong. Rec. S4521 (daily ed. May 15, 1997) (letter from Dr. David Grimes, Clinical Professor of Obstetrics & Gynecology, Univ. of N.C., describing intact D&E for patient with HELLP syndrome involving liver failure).

iii. Several physicians reported the special benefits of intact D&E in the case of placental abnormalities. 149 Cong. Rec. S3600 (daily ed. Mar. 12, 2003) (statement of Sen. Feinstein) (letter from Dr. Philip D. Darney, Chief of Obstetrics & Gynecology, San Francisco Gen. Hosp., describing cases of placental abnormalities where intact D&E was "critical to providing optimal care"); JA 513-14 (intact D&E reduces risk of uterine rupture where the placenta is abnormally adherent to the uterine wall).

iv. Several physicians testified that intact D&E has special benefits where an anomaly greatly enlarges fetal parts. If the head or abdomen is very large, to perform

a disarticulation D&E, the physician must open the forceps to the full dimension of the enlarged part – a "very wide degree" – and the wider the forceps are opened, the more likely "to traumatize or perforate the uterus." JA 503-04; *see also* JA 297-99.

v. Reduced risk of complications during an intact D&E is "particularly important" for women with serious medical problems because "if that woman experiences a complication, [it] may be catastrophic compared to a woman . . . . without preexisting medical problems." JA 461. A woman with serious medical problems "doesn't have the physiological reserve to cope with a complication like uterine perforation, or laceration, or heavy bleeding." JA 461-62; *see, e.g.*, JA 294-96 (attempted intact D&E for patient with scleroderma who was in an unstable medical condition).

In sum, the District Court's findings that intact D&E is significantly safer than alternative methods, especially for some women, and poses no special risks, are overwhelmingly supported by the trial and congressional records, and should not be disturbed.

2. Because the Overwhelming Evidence of Significant Safety Benefits Constitutes "Substantial Medical Authority," a Health Exception is Required

The overwhelming support for the finding that intact D&E is "significantly safer than [other methods]" (PA 147a) – and the absence of well-informed contrary testimony – compels finding that the "substantial medical authority" quantum of proof has been met. PA 215a (since *Stenberg*, "the majority of highly-qualified experts . . . believe intact D&E to be the safest . . . procedure under certain circumstances"); *see also NAF*, 437 F.3d at 278

("[u]nquestionably such 'substantial medical authority' exists").

Compared with *Stenberg*, many more experts testified here in support of the medical need for intact D&E. These experts have direct personal experience actually performing and teaching intact D&E. *Cf. Stenberg*, 530 U.S. at 966-67 (Kennedy, J., dissenting) (none of Dr. Carhart's experts had performed intact D&E). Also, while the *Stenberg* Court accepted Nebraska's argument that intact D&E is used only by "a 'handful' of doctors," 530 U.S. at 933 (citation omitted), the record here shows that it is used at preeminent medical institutions in major cities nationwide that are leaders in the medical field. PA 205a. Moreover, while no peer-reviewed studies of intact D&E existed when *Stenberg* was decided, the recent Chasen study supports the safety benefits of intact D&E. PA 143a. In sum, there is more and better evidence of "substantial medical authority" here than in *Stenberg*. *See NAF*, 437 F.3d at 287 (record here is "even more compelling" than in *Stenberg*).

The Government failed to adduce "substantial and objective medical evidence to demonstrate [that it] had considerable support for its conclusion that the ban create[s] a substantial risk to no woman's health." *Stenberg*, 530 U.S. at 969 (Kennedy, J., dissenting). Thus, the Government is left only with the congressional findings and its own rhetoric. But characterizing the health benefits as "marginal" (*e.g.*, Gov't Br. 29), or likewise characterizing the women who need intact D&E as a "tiny category of hypothetical cases" (*id.*), does not make it true. To the contrary, the record overwhelmingly demonstrates that the risk of significant harm is real (PA 147a) and that the women subjected to this risk are not "hypothetical." The District Court correctly ruled that "substantial medical authority"

supports the need for a health exception to prevent "tragic health consequences." 530 U.S. at 937-38.

C. The Congressional Findings Cannot Trump the Need for a Health Exception

The Government rests its case on the hope that this Court will simply defer to the congressional findings. However, whether independently reviewed or reviewed deferentially, the findings cannot trump the need for a health exception because – as the lower courts held – they are patently unreasonable.

1. Deferential Review is Not Appropriate Here

The Court should decline to review the congressional findings with "a high degree of deference" (Gov't Br. 19) (sometimes referred to as "substantial evidence" review (*id.* at 21)), for three reasons.

First, Congress intentionally passed the Act to circumvent the constitutional rule established in *Stenberg* that a health exception is needed if "substantial medical authority supports the proposition that banning [intact D&E] could endanger women's health." *Stenberg*, 530 U.S. at 938; *see* Statement of Case, *supra*. Because the findings are simply a bald-faced attempt to end-run *Stenberg*'s constitutional rule, they are entitled to no deference. *Dickerson v. United States*, 530 U.S. 428, 437 (2000) ("Congress may not legislatively supersede our [constitutional] decisions"); *City of Boerne v. Flores*, 521 U.S. 507, 536 (1997).

Second, "substantial evidence" review is inapplicable because it is fundamentally at odds with *Stenberg* and prior cases guaranteeing the primacy of maternal health. If substantial evidence review were all that were required to override the need for a health exception, a legislative majority could invite witnesses to give testimony against an abortion method in support of pre-determined findings, and

this Court would have to defer to those findings. This would be so even if the "substantial medical authority" quantum of proof was met by the legislative minority's witnesses, or was proven at a trial challenging the law.

Substantial evidence review would thus set the stage for dismantling one of the core principles of this Court's abortion jurisprudence: majority will, not pregnant women's health, would be the "paramount" concern when the government regulates abortion. *Thornburgh*, 476 U.S. at 769. Indeed, under the Government's legislative deference theory, the quantum of proof needed to omit a health exception would be *less protective* of women's health than the standard proposed by the *Stenberg* dissenters. *Cf. Stenberg*, 530 U.S. at 969 (Kennedy, J., dissenting) (health exception *not* needed only if "substantial and objective medical evidence . . . demonstrates [that the legislature] had considerable support for its conclusion that the ban created a substantial risk to no woman's health").

Third, the Act burdens the right to choose abortion. When reviewing legislation that – like the Act – is subject to heightened scrutiny, this Court has always engaged in a searching, independent review of any constitutionally relevant facts. *See, e.g., Sable Commc'ns of Cal., Inc. v. FCC*, 492 U.S. 115, 129 (1989) (standard of review cannot "foreclose our independent judgment of the facts bearing on an issue of constitutional law"); *Landmark Commc'ns, Inc. v. Virginia*, 435 U.S. 829, 843 (1978) (legislative deference "cannot limit judicial inquiry when First Amendment rights are at stake."); *accord Casey*, 505 U.S. at 851 ("where reasonable people disagree the government can adopt one position or the other," but not where "the choice . . . intrude[s] upon a protected liberty").[21] Independent review

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[21] None of the cases the Government cites for the proposition that the Court defers to congressional findings on complex medical and

is particularly important here because the findings are likely to be dispositive of a constitutional right. If the Court were required to defer blindly to them, Congress could – under the guise of making "factual findings" – do an end run around this Court's constitutional rulings.

The Government is wrong that this Court applies a "single standard" in reviewing congressional findings. Gov't Br. 19, 20. Rather, this Court often undertakes an independent and searching review to ensure that congressional fact-finding is not used to unduly burden individual liberties. *See, e.g., Ashcroft v. Free Speech Coal.*, 535 U.S. 234, 240, 253-54 (2002) (invalidating ban on virtual child pornography despite congressional findings that such pornography increases sexual exploitation of children); *cf. United States v. Morrison*, 529 U.S. 598, 614 (2000) (invalidating part of Violence Against Women Act despite extensive congressional findings on economic impact of gender-motivated violence).[22] It should do so here.

2. No Deference is Due Because the Findings are Not "Reasonable"

In any event, the Court need not decide the appropriate degree of deference because the Government cannot prevail even under the "substantial evidence" standard of *Turner Broadcasting System, Inc. v. Federal Communications Commission*, 512 U.S. 622 (1994) ("*Turner I*"). The three district courts that reviewed the Act did what *Turner I* instructed: they followed their "obligation to exercise independent judgment" and used the evidence to

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scientific issues (Gov't Br. 19) involved a fundamental right. *See generally* Br. of Constitutional Law Professors David L. Faigman & Ashutosh A. Bhagwat, *et al.*, as *Amici Curiae* in Support of Respondents, at 26-27.

[22] Similarly, in *Bd. of Trustees of the Univ. of Ala. v. Garrett*, 531 U.S. 356 (2001), Gov't Br. 19-20, Congress made findings that it had authority to enact the legislation at issue, and the Court rejected those findings.

assess whether Congress had "drawn reasonable inferences based on substantial evidence." *Turner I*, 512 U.S. at 666; *see also Turner Broad. Sys. v. Fed. Commc'n Comm'n*, 520 U.S. 180, 211 (1997) ("*Turner II*"). Notably, all three district courts concluded that the findings are *not* reasonable and merit no deference. PA 172a ("Congress has not drawn reasonable inferences based on substantial evidence"); *accord* PA 194a; *Carhart*, 331 F. Supp. 2d at 1008 (same); *NAF*, 330 F. Supp. 2d at 487 (same). Indeed, the District Court found "that all of the government's own witnesses disagreed with many of the specific congressional findings." PA 195a; *see also NAF*, 330 F. Supp. 2d at 482 (Government experts "disagreed with almost all of Congress's factual findings").

Unlike in *Turner I*, the bulk of the congressional findings here consist of either legal argument or Congress's value judgments. The findings that at least appear to be factual can be broken down into four categories. The findings in each category are false, and therefore "unreasonable" and not entitled to deference.[23]

i. The first category of findings asserts that there is a "consensus" of opinion against "partial-birth abortion," including that it is disfavored in the medical community, absent from medical school curricula, and unrecognized by mainstream medicine. Act §§ 2(1), (2), (14)(B), (C), (O). As the Ninth Circuit correctly ruled: "Even the most cursory review of the Act and the congressional record . . . reveals that no such medical consensus exists, a fact that the government essentially concedes in its brief . . . and that is fully confirmed by the evidence introduced [at trial]." PA 22a; *see also* PA 196a ("the evidence available to

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[23] This excludes legal arguments couched as "findings," such as those arguing for deference, summarizing and criticizing *Stenberg*, and self-servingly reporting that Congress has "substantial evidence" for its findings. *See, e.g.*, Act §§ 2(3)-(4), (6)-(13), (14)(D), (G), (H).

Congress . . . very clearly demonstrates . . . that there is no medical or ethical consensus regarding either the humanity, necessity, or safety of [intact D&E]"). The lack of consensus was confirmed at trial. *See* § I.B.1, *supra* (evidence of safety of intact D&E confirms that there is no consensus against its use, it is not "disfavored," and it is part of leading medical schools' curricula); JA 673 (Dr. Sprang, agreeing that the AMA could reach no ethical consensus), 861.

ii. The finding in the second category asserts that there is no "credible medical evidence" supporting the safety of "partial-birth abortion." Act § 2(14)(B). This finding is unreasonable and cannot be accepted because Congress very definitely had before it, and there clearly is, "credible medical evidence" supporting the safety of "partial-birth abortion." Numerous physicians and medical organizations submitted statements to Congress attesting to the safety of intact D&E. *See* § I.B.1, *supra*. In addition, the amicus brief submitted by ACOG to this Court in *Stenberg* was entered into the congressional record. ER 1233-47. Moreover, that "credible medical evidence" was overwhelmingly confirmed by the evidence presented at trial. PA 143a-44a; *see* § I.B.1, *supra*.

iii. The findings in the third category assert that "partial-birth abortion" carries health risks and a ban will advance women's health. Act §§ 2 (14)(A), (F), (O). These findings are also unreasonable because – as even the Government's witnesses agreed – intact D&E is no riskier than disarticulation D&E, and may well be safer. PA 145a, 200a-02a (rejecting congressional findings related to alleged intact D&E complications).

iv. Apparently recognizing the outright falsity of the findings in categories (i)-(iii), the Government now ignores them and asks the Court to uphold the Act based exclusively on the findings in the fourth category –

Congress's assertion that "partial-birth abortion" "is never medically indicated" (Act §§ 2(14)(E), (O)) to preserve the health of pregnant women. Gov't Br. 21. As the courts below found, "substantial medical authority" believes that intact D&E is significantly safer than other methods and is medically indicated in some circumstances. *See* § I.B, *supra*. Given the weight of this evidence, this Court should not defer to a finding based on testimony from physicians without second-trimester abortion expertise.[24]

Moreover, any assessment of these findings must be informed by the serious flaws in Congress's politicized, pre-determined fact-finding process.[25] *See* Statement of Case, *supra*. Seen through that lens, and given the objective falsity of so many of them, it is apparent that none of the congressional findings are entitled to deference.

D. *Stenberg* Should Not Be Overruled

Because the "substantial medical authority" standard is met and the unreasonable congressional findings are entitled to no deference, this Court cannot uphold the Act without overruling *Stenberg*. Regardless of whether a

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[24] The Government cites congressional testimony of Drs. Kathi Aultman, Curtis Cook, Mark Neerhof, Nancy Romer, and Pamela Smith. Carhart Gov't Br. 31-33. None of these physicians are experts in second-trimester surgical abortion, and several, if not all, oppose abortion by any method. Statement of the Case, *supra* (Cook and Neerhof); *Richmond Med. Ctr. For Women v. Gilmore*, 55 F. Supp. 2d 441, 449 (E.D. Va. 1999) ("Dr. Kathi Aultman . . . was not current on the medical aspects of abortion"); *Planned Parenthood of Greater Iowa, Inc., v. Miller*, 30 F. Supp. 2d 1157, 1165 n. 9 (S.D. Iowa 1998) (same); ER 53 (Dr. Smith was president-elect of the American Association of Pro-Life Obstetricians and Gynecologists; presumably, she opposes all abortions); ER 161-63 (Dr. Romer did not report any experience performing abortions).

[25] There is no basis for the Government's claim that the Court should defer to Congress's so-called credibility determinations. Gov't Br. 25-26. *Akins v. Texas*, 325 U.S. 398 (1945), the only case it cites for that assertion, did not involve congressional findings.

majority of this Court agreed with the *Stenberg* majority, "the principles of *stare decisis* weigh heavily against overruling it now." *Dickerson*, 530 U.S. at 443. The considerations identified in *Casey* to test whether "overruling a prior decision [is consistent] with the ideal of the rule of law," 505 U.S. at 854, do not support overturning *Stenberg*. Its holding has not proven unworkable in practice; doctors at leading medical institutions nationwide have been trained to use this technique; pregnant women have benefited from access to safer procedures; *Stenberg* has been applied consistently by the lower courts; and there have been no legal or factual developments that would undermine *Stenberg*'s underpinnings. Indeed, not only do the legal foundations of *Stenberg* remain strong, the principle that women's health must remain paramount when the government regulates abortion was unanimously reaffirmed last term in *Ayotte*.

Under these circumstances, overruling *Stenberg* would lack the "special justification" needed to overrule a precedent recognizing a constitutional liberty interest. *Harris v. United States*, 536 U.S. 545, 557 (2002); *cf. Lawrence v. Texas*, 539 U.S. 558 (2003). Rather, there would be no "justification beyond a present doctrinal disposition to come out differently from the Court" of 2000. *Casey*, 505 U.S. at 864. That result would "invite[] the popular misconception that [the Court] is little different from the two political branches of the Government. No misconception could do more lasting injury to this Court and to the system of law which it is [its] abiding mission to serve." *Mitchell v. W.T. Grant Co.*, 416 U.S. 600, 636 (1974) (Stewart, J., dissenting); *see also Casey*, 505 U.S. at 864 (same); *cf. Bush v. Vera*, 517 U.S. 952, 985 (1996) ("Our legitimacy requires, above all, that we adhere to *stare decisis*, especially in such sensitive political contexts . . . where partisan controversy abounds.").

Reaffirming *Stenberg* is also imperative because its reasoning applies, rather than departs from, the careful balance established in *Casey*. There, the Court held: "the essential holding of *Roe* forbids a State to interfere with a woman's choice to undergo an abortion procedure if continuing her pregnancy would constitute a threat to her health." 505 U.S. at 880. The core principle that pregnant women must be able to protect their health despite abortion restrictions would surely be hollow if doctors were forbidden to treat patients by performing the "significantly safer" intact D&E method where appropriate.

Casey departed from *City of Akron v. Akron Center for Reproductive Health, Inc.*, 463 U.S. 416 (1983), and *Thornburgh* only in recognizing that the interest in potential life is "substantial" throughout pregnancy. 505 U.S. at 876-78. *Casey* nowhere suggests that the state interest in potential life justifies a restriction that puts women's health at risk by banning the safest pre-viability abortion method – without a health exception.[26]

The Government argues that two interests justify the ban – the interest in potential life and in prohibiting infanticide. Gov't Br. 10, 14, 28. Neither applies here. An intact D&E ban does not save fetal life, *Stenberg*, 530 U.S. at 951 (Ginsburg, J., concurring); it merely pushes women to a less safe method. *Cf. Harris v. McRae*, 448 U.S. 297, 345 (1980) (Marshall, dissenting) (the "interest in protecting fetal life is not a legitimate one when it is in conflict with 'the preservation of the life or health of the mother.'") (quoting *Roe*, 410 U.S. at 165). As to "infanticide," prior to viability

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[26] Because intact D&E is significantly, not marginally, safer than disarticulation D&Es (PA 147a), requiring a health exception will not deny government a "meaningful constitutional role in regulating abortion" (Gov't Br. 11); it merely ensures that the government's role is to protect citizens rather than harm them.

when the fetus cannot survive regardless of how it is removed from the uterus, "it is difficult to rest the Act's constitutionality upon an interest in maintaining a distinction between infanticide and abortion." *NAF*, 437 F.3d at 292 n.9 (Walker, C.J., concurring); *cf. NAF*, 437 F.3d at 288 (noting that another federal law, 1 U.S.C. § 8(a), explicitly draws the line against "infanticide" – in a manner that clarifies that intact D&E is not infanticide – by defining "child" as an infant "born alive" and defining "born alive" as the "*complete* expulsion or extraction" of a living fetus from its mother) (emphasis added).

While the Act serves an interest in promoting a moral judgment against intact D&E, this Court has repeatedly held that its "obligation is to define the liberty of all, not to mandate our own moral code." *Casey*, 505 U.S. at 850; *Lawrence*, 539 U.S. at 571 (citations omitted). Thus, in *Casey*, this Court acknowledged that some view abortion as "nothing short of an act of violence against innocent human life," yet ruled that this view cannot trump the woman's liberty interest. 505 U.S. at 851-53. So here, intact D&E cannot be banned, especially given its significant safety benefits, on the grounds that some view it as immoral.[27] In sum, using morality as justification for forcing women to have significantly less safe pre-viability abortions would undermine *Casey*, as well as *Stenberg*. The Court should not go down this path.

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[27] Notably, many of the Government witnesses expressly testified that they did not find intact D&E more objectionable than disarticulation D&Es (PA 199a) – undermining the very premise of the congressional findings and the Government's defense of the Act, namely that intact D&E is particularly unacceptable.

II. THE ACT IMPOSES AN UNDUE BURDEN ON WOMEN'S RIGHT TO PRE-VIABILITY SECOND-TRIMESTER ABORTIONS AND IS UNCONSTITUTIONALLY VAGUE

The Act is an undue burden because physicians will be chilled from performing any D&E for fear of running afoul of its terms. It also fails to give fair notice of the prohibited conduct, rendering it unconstitutionally vague.

A. The Act Bans D&E Abortions and Therefore Imposes an Undue Burden

The lower courts found that any D&E when performed in the safest manner can violate the Act, and that physicians can neither predict nor control when this will occur. *See* PA 80a-89a, 26a-33a. As a result, the Act will chill doctors from performing any D&E, or force them to take steps to avoid prosecution, despite their best clinical judgment. *Id.* The Government's argument that there is no undue burden because "standard D&Es" remain available (Gov't Br. 30-35), fails because it does not meaningfully distinguish between permitted and banned D&Es.

1. A Law That Bans D&E Abortions Imposes an Undue Burden

Women have a "right . . . to choose to have an abortion before viability . . . without undue interference from the State." *Casey*, 505 U.S. at 846. Thus, before viability, an abortion regulation may not "impose[] an undue burden on a woman's ability to make this decision." *Id.* at 874, 878. In *Stenberg*, the parties and the Court all agreed that a statute that bans D&Es as a general category imposes an undue burden. 530 U.S. at 938. This is because the vast majority of pre-viability, second-trimester abortions are D&Es, including approximately 95% of abortions between 16 and 20 weeks of pregnancy and 85% after 20

weeks of pregnancy. PA 58a.[28] Because the Nebraska statute caused "those who perform [D&E procedures to] fear prosecution, conviction and imprisonment," it would have chilled doctors from performing D&Es, imposing an "undue burden upon a woman's right to make an abortion decision." *Stenberg*, 530 U.S. at 945-46; *see also Danforth*, 428 U.S. at 75-79 (invalidating ban on "the most commonly used" second-trimester method). The same is so here.

2. The Record Proves That the Act Bans D&Es

a. The District Court Finding That Any D&E May Violate the Act Should Not Be Disturbed

The District Court found that "any abortion using the D&E . . . method could proceed so as to violate the Act when performed in the safest manner." PA 83a. This conclusion is based on detailed factual findings explaining how D&Es are performed.[29] In particular, the District Court found that D&Es by any variant are performed in two steps: first the

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[28] Virtually all post-first-trimester abortions are by D&E or induction. *See* PA at 57a. For some women, inductions are contraindicated. *See* PA 125a-28a. Other women strongly prefer D&E, which is performed on an outpatient basis, to induction, which requires hospitalization and labor of up to two days. *See* PA 58a n.5, 61a-63a, 129a. A tiny number of post-first-trimester abortions are performed by abdominal surgery in which either the fetus is extracted through the woman's abdomen (hysterotomy) or the uterus is removed with the fetus in it (hysterectomy). PA 63a. These procedures are "major surgery and are not recommended except in the case of extreme emergency" because of their relatively high rate of morbidity and mortality. *Id.*

[29] The Government cannot argue that the District Court's findings are "clearly erroneous" as they are based on the testimony of highly-qualified ob-gyn experts with experience and expertise in second-trimester surgical abortions, and on admissions from the Government's witnesses. *See* § I.B, *supra*. The Government adduced no evidence regarding the scope of the Act. *See* PA 75a (Government "devoted very little attention to the undue burden issue," and "mistakenly conflate[d]" it with the issue of vagueness).

cervix is dilated, and then the uterus is surgically evacuated by drawing the fetus out through the cervix and vagina. PA 58a, 60a. Most commonly, the fetus is extracted in parts, with disarticulation "occur[ing] only when the fetus meets resistance that restricts the motion of the fetus." *Stenberg*, 530 U.S. at 939; *see* PA 67a n.11 (completely intact extraction occurs only rarely). The disarticulation occurs when "traction is created between the instrument and the counter-traction of the internal os of the cervix" due to a fetal part being too big to pass through and lodging in the cervical opening. *Stenberg*, 530 U.S. at 939 (quotation and citation omitted); *see also* JA 73, 359, 960.

When performing any D&E, sometimes the dilation permits the fetus to be extracted intact or relatively intact to the torso or skull before a larger part lodges in the cervix. PA 81a-82a; JA 219-20, 279-80, 367-69, 438, 962; *cf.* JA 504. The Government witnesses agreed. *See* JA 718-19 (Dr. Shadigian agrees that in any D&E the fetus may be removed to the torso), 571 (Dr. Bowes agrees that in any D&E the fetus may be extracted to the skull with one pass of instruments). While the frequency of intact or relatively intact removal varies, for the testifying physicians, the occurrences "ranged from between 5% to 33% of all D&Es performed, with most doctors reporting occurrences of around 5-15% of the time." PA 67a.[30]

Physicians cannot assess how likely an intact or relatively intact extraction will be until they remove the

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[30] Abortions in which the fetus is extracted intact or relatively intact are referred to by a variety of terms, including "intact D&E," "intact variant of D&E," and "dilation and extraction" or "D&X." "Most significantly," as the District Court found, "all of the testifying physicians who have performed intact extractions refer to this procedure as a variant of D&E, and not as an entirely separate procedure. . . . The only physicians who referred to it as a separate procedure were witnesses who had never performed the procedure." PA 68a; *see also* JA 51, 52, 129, 220, 280-81, 961.

dilators and assess the amount of dilation, the lie of the fetus, and the depth of the vagina, among other considerations. *See* JA 479-83; *see also* JA 220-21, 281, 435. Again, the Government's witnesses agree. *See* JA 1003 (Dr. Lockwood testified that "the decision was made most often . . . during the performance of the procedure to reflect . . . the extent of cervical dilation"). For these reasons, the District Court found: "[t]he potential for a largely intact removal cannot be ascertained until the surgical procedure has already begun." PA 66a; *see also* JA 143-44, 220-21, 371, 939.[31]

Regardless of how dilation is achieved, once an intact or relatively intact fetus is extracted to where a larger part lodges at the cervix with insufficient dilation to continue the extraction, the physician must take steps to complete the procedure. Among the options are "disarticulation . . . , or compressing or decompressing the skull or abdomen or other fetal part that is obstructing completion of the uterine evacuation." PA 83a; *see also* JA 73, 132, 142-43, 282-83, 368-70, 439, 963-65. The Government's witnesses agree. *See* JA 719.[32] If the fetus is still living when it is extracted past the navel or to the head and lodges there, the physician knows that any of the steps taken to complete the procedure will cause fetal demise. PA 83a; *see also* JA 77, 82, 965.

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[31] While most physicians use a uniform dilation protocol for all D&Es at any point in pregnancy (*see, e.g.*, JA 440, 480, 481), a few testified that if intact extraction would have particular benefits for a patient, they would take steps to dilate the cervix more than usual to increase the likelihood of intact removal. *See* PA 67a; JA 294-97; *cf.* JA 374-76.

[32] When this happens, Government witness Dr. Cook prefers to make multiple incisions in the woman's cervix, rather than to injure the fetus – *even pre-viability* when the fetus cannot survive. *See* JA 784-88. Planned Parenthood's witnesses testified that this technique is highly inappropriate prior to viability because, *inter alia*, it poses serious risks to the woman's future fertility. JA 291-92, 522.

Two underlying facts are particularly critical. First, "the amount of cervical dilation that can be achieved is individual to each woman and cannot necessarily be controlled." PA 59a; *see also* JA 216, 436, 982. Second, in any D&E, the physician tries to reduce the number of times instruments are inserted through the cervix and into the uterus by extracting as much of the fetus as possible with each instrumental pass. JA 72, 214, 241, 438, 909-10, 960, 962. Once again, the Government's witnesses agree. *See* JA 570, 718, 999-1000.

When intact, or relatively intact, extraction is possible, it would increase the risks of perforation, hemorrhage and infection to unnecessarily place instruments in the uterus to cause disarticulation. JA 214, 221, 279, 281-82, 962-63; *see also* JA 1000 (Government witness Dr. Lockwood agrees). Thus, in any D&E, when the dilation and other factors suggest that the fetus can be extracted intact, the physician attempts to do so in order to reduce the instrumentation in the woman's uterus, and thereby reduce the risk of serious complication.

Based on these findings, the District Court concluded that any D&E may be banned by the Act "when performed in the safest manner." PA 83a. Referencing the Act's definitional language, the District Court explained:

> In performing all D&E's . . . physicians "deliberately and intentionally" extract the fetus from the woman's uterus and through her vagina . . . . [which] is called a "vaginal delivery." . . . *Plaintiffs' and the government's experts agree that in any D&E . . . a living fetus may be extracted in a breech presentation until some "part of the fetal trunk past the navel is outside the body of the mother."* . . . In any D&E . . . if the fetus has been brought to th[is] point . . . , a physician may then, in order to complete the

> abortion in the safest manner, need to perform an "overt act," short of completing delivery, that the physician knows the fetus cannot survive, if it still living, and that "kills" the fetus.

PA 81a-83a (citations to witnesses on both sides omitted) (emphasis added). Accordingly, "any abortion performed using the D&E . . . method could proceed so as to violate the Act." PA 83a; *see also* PA 84a ("When beginning a D&E . . . , a physician cannot predict if [it] . . . will . . . violate[] the Act, but the physician knows that [it] is a possibility."). The Act thus unconstitutionally burdens women's pre-viability, second-trimester abortion right. *Stenberg*, 530 U.S. at 945-46.

b. The Government's "Standard D&E" Theory Cannot Save the Act

The Government argues that the Act does not impose an undue burden because it permits so-called "standard D&Es." Gov't Br. 31-35. The problem for the Government is that the distinctions it proposes between banned and protected D&Es depend on factual premises that are contradicted by the District Court's fact-finding and the record, and on semantic distinctions that do not withstand scrutiny. There remains no clear demarcation between banned and permitted D&Es. As a result, the Act will chill the provision of all D&Es.

i. First, the Government suggests that the Act's "anatomical 'landmark[]'" language excludes "standard D&Es." Gov't Br. 31-33. It bases this on its assertions that "[i]n a standard D&E," the physician: "dismembers the fetus while the remainder . . . is still inside the womb"; "use[s] the cervix to restrain the body of the fetus to enable dismemberment"; and "deliver[s]" through the cervix a "smaller portion of the fetus," which is then disarticulated. According to the Government, these

assertions show that the fetus is not delivered past the Act's "anatomical 'landmarks'" in a "standard D&E." *Id.*

This description, however, contradicts the District Court's findings and the record. Perhaps that is why the Government cites no evidence for its theory; nor could it.[33] There is no "standard" degree to which a fetus is extracted before it lodges in the woman's cervix. Experts on both sides testified that the number of times the physician needs to insert instruments into the uterus to extract the fetus varies, and thus, there is no standard degree to which the fetus is extracted before an obstructing part must be disarticulated or reduced in size. *See supra.* Physicians do nothing to "restrain" the extraction in any D&E; rather they extract as much of the fetus as possible with each pass of the instruments, and do not disarticulate, compress or decompress until necessary to complete the procedure. *See supra; see also Stenberg*, 530 U.S. at 939.

It is, therefore, misleading to argue that the "anatomical landmark" language protects "standard D&Es." This language simply legislates a particular theory – divorced from the facts – of what constitutes a "standard" degree of extraction before demise in a "standard D&E," *i.e.*, less than "past the navel," leaving some "standard D&Es" legal, while making others a federal crime. The Government recognizes this when it argues that the overt act requirement protects physicians who perform a "standard D&E abortion *not already excluded* by the anatomical 'landmark' requirement." Gov't Br. 32 (emphasis added).

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[33] The testimony cited for the Government's claim that in "standard D&Es" the "physician dismembers the fetus while the remainder of the fetus is still inside the womb" (Gov't Br. 31, 32), merely describes how some physicians grasp a fetus with instruments. JA 144-47, 452. It does not conflict with the District Court's findings that during a D&E, a part of a fetus past the navel may be delivered before the physician must disarticulate to complete the procedure.

ii. Second, the Government asserts that the Act's "overt act" requirement excludes the remaining "standard D&Es" because in a "standard D&E" the "'delivery' of a portion of the fetus is incidental and integral to . . . the performance of the lethal act," and is not a separate "overt act, other than completion of delivery." Act, § 3(b)(1)(B). Gov't Br. 32. Even accepting this premise, *arguendo*, the problem is: how is a physician to know what steps that cause demise are legal because they are "incidental and integral" to the delivery, and what steps are not? As the District Court found: in any D&E the physician may "extract[] the fetus intact until 'part of the fetal trunk past the navel is outside the woman's body,' but . . . is not extracted so far that the calvarium lodges at the cervical opening," and may then, "in order to complete the abortion in the safest manner, need to perform an . . . act," such as "disarticulation, . . . or compressing or decompressing the skull or abdomen or other fetal part that is obstructing completion of the uterine evacuation." PA 82a-83a. Any of these steps will cause fetal demise; yet all of these steps would be undertaken to complete the delivery, and thus could be understood as "incidental and integral" to it.

The Government's position is difficult to follow even as among disarticulation D&Es. Sometimes the Government states that disarticulation is permitted as "incidental and integral" to delivery; other times, it states that it is a banned "overt act." *Compare* Gov't Br. 32 (permitting post-landmark "standard D&Es" where disarticulation is "incidental and integral" to delivery) *with* Gov't Br. 33 ("delivery-followed-by-dismemberment" abortions are not "standard D&Es"). If there is a meaningful distinction between permitted and banned instances of completing the abortion in these circumstances, the Government has not identified it.

iii. Third, the Government argues that the Act's "for the purpose of" requirement excludes "standard D&Es." It posits two scenarios as illustrative of abortions that would meet the "for the purpose of" language, violating the ban. In the first, the physician extracts the fetus "beyond a specified anatomical 'landmark' for the purpose of subsequently killing the living fetus by crushing the fetal skull," in a separate overt act. Gov't Br. 33. However, the Government cites nothing suggesting this scenario happens. Nor could it. Planned Parenthood's experts testified that in *no* D&E do they extract the fetus to any anatomical point "for the purpose of" doing anything other than completing the abortion as safely as possible. *See* JA 309-10; *see also* JA 72, 82-83, 128, 214, 277, 476; *cf.* JA 568-69 (Bowes) (physician's intent is always to end the pregnancy in the way safest for the woman).

The Government's second banned scenario references the Ninth Circuit's opinion, describing an abortion where the physician delivers the fetus "for the purpose of subsequently killing the living fetus *by dismemberment*." Gov't Br. 33 (emphasis in original).[34] However, the Ninth Circuit opinion reveals that it was discussing abortions where the physician delivers the fetus past the Act's "anatomical landmarks" (Gov't Br. 32) and then "disarticulat[es] . . .or compress[es] the abdomen or other fetal part that is obstructing the completion of the

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[34] The Government argues that there is no record evidence that doctors ever extract the fetus past the specified points "for the purpose of subsequently killing the living fetus *by dismemberment*." Gov't Br. 33 (emphasis in original). Planned Parenthood agrees. But as noted above, there is also no record evidence that physicians extract the fetus to the specified points "for the purpose of" performing *any* lethal act other than completing the delivery. It is thus hard to discern the difference that the Government is positing between disarticulation or dismemberment, on the one hand, and any other action that a physician takes when a fetal part obstructs the completion of the abortion.

uterine evacuation." PA 30a. It is unclear why such an abortion is banned, given that (as described), the lethal act is necessary to removing an obstructing part, and thus is "incidental and integral" to the delivery. Gov't Br. 32.

The Government thus fails to explain how the "for the purpose of" language narrows the Act.

c. Any "Specific Intent" Requirement Does Not Save the Act

The Government claims that the Act is limited because it "applies only where the person performing the abortion has the specific intent, at the outset of the procedure, to deliver the requisite portion of the fetus for the purpose of performing the ultimate lethal act," which must be an act that is not "incidental and integral" to the delivery. Gov't Br. 32. This argument fails based on the Act's plain language. While Congress included several explicit scienter provisions in the Act, "specific intent" is not one of them.[35] The Act is thus not "readily susceptible" to the Government's "specific intent" construction. *Reno v. Am. Civil Liberties Union*, 521 U.S. 844, 884 (1997).

However, even if the Act were construed to require "specific intent," physicians could not be assured of its scope. As this Court has noted, specific intent is a "difficult legal concept" (*Liparota v. United States*, 471 U.S. 419, 433 n.16 (1985)) that "has been the source of a good deal of confusion," which "has led to a movement away from its use," including its abandonment by the Model Penal Code. *United States v. Bailey*, 444 U.S. 394, 403-04 (1980); *cf. Liparota*, at 433 n.16 (jury instructions regarding specific intent have

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[35] In the lower courts, the Government argued that the Act's text-based *mens rea* requirements cure the overbreadth and vagueness. Here, it has abandoned that argument, which was properly rejected by the lower courts. PA 94a-95a, 39a-40a.

been "criticized as too general and potentially misleading").

It is unclear, for example, whether a physician would be found to have the "specific intent" to perform an intact D&E based on the fact that he always attempts to reduce uterine instrumentation by extracting the fetus as intact as possible, and thus, as the District Court found, he "cannot predict if the procedure . . . will . . . violate[] the Act, but . . . knows that [it] is a possibility." PA 84a. Does the intent to reduce uterine instrumentation by removing the fetus as intact as possible bring a physician within the reach of the Act? Does the knowledge that, in most cases, the physician will have to perform an act (disarticulation, compression or decompression) in order to complete the delivery, and which will cause the demise of the fetus, constitute specific intent to perform a "partial-birth abortion," especially given the success rate in extracting the fetus intact to the head ranging from 5-33%?

Engrafting an additional *mens rea* element onto the Act neither answers these questions nor clarifies the parameters of the criminal *actus reus*. Thus, it does not alleviate the chill on physicians. Rather, the specific intent construction rests on the Government's "standard D&E" theory that fails to meaningfully distinguish between permitted and banned overt acts. A heightened *mens rea* requirement is no limitation if physicians do not know what actions are criminal if performed with that mental state.

In sum, the scienter provisions do not limit the Act in a manner on which physicians can rely. As a result, those who perform any D&E must "fear prosecution, conviction, and imprisonment[; t]he result is an undue burden upon a woman's right to make an abortion decision." *Stenberg*, 530 U.S. at 945-46.[36] *See* PA 84a-85a (describing the "significantly

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[36] Two ob-gyns who were not covered by an injunction testified

negative impact" enforcing the Act would have on Planned Parenthood and its patients); *see also* JA 162-63.

B. The Act is Impermissibly Vague and Should Not Be Narrowly Construed

The lower courts correctly ruled that the Act is unconstitutionally vague because it "fails to define clearly the medical procedures it prohibits."[37] PA 33a; *accord* PA 92a-95a. The Act thus forces physicians to "guess at its meaning and differ as to its application." *Smith v. Goguen*, 415 U.S. 566, 572 n.8 (1974). It therefore "trap[s] the innocent by not providing fair warning" and encourages "arbitrary and discriminatory enforcement." *Grayned v. City of Rockford*, 408 U.S. 104, 108 (1972). The Act's failure to provide adequate notice raises particular concern because it "implicates a constitutionally protected right" and "imposes criminal penalties." PA 33a-34a; *accord* PA 91a; *see also Kolender v. Lawson*, 461 U.S. 352, 358 n.8 (1983) (when "a statute imposes criminal penalties, the standard of certainty is higher"); *Colautti v. Franklin*, 439 U.S. 379, 391 (1979) (review is more stringent where uncertainty "threatens to inhibit the exercise of constitutionally protected rights") (citations omitted).

If the Act does not place physicians at risk of running afoul of the ban during every D&E they perform, which is – as the District Court ruled – how it must be understood

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they had stopped performing D&Es. *See* JA 235-36 ("I am currently going to stop doing D&Es . . . [b]ecause I think it would be unpredictable for me to know whether I violate the act."), 935-36 ("I don't do [D&Es] anymore . . . [b]ecause of the law, because I heard that I might go to prison, and because I'm not clear on what I can and cannot do."); *cf.* JA 451.

[37] The Act is also unconstitutionally vague because it applies only to abortions performed "in or affecting interstate . . . commerce." *See generally* Br. of *Amicus Curiae* California Medical Association in Support of Respondents. This aspect of Planned Parenthood's vagueness claim was raised, but not reached by the lower courts. PA 89a n.15; JA 1082 ¶ 30.

based on the plain meaning of its terms and an understanding of D&E practice, then Planned Parenthood does not know what the Act bans and permits.

The Government argues that the Act is not vague because it "unambiguously excludes standard D&E abortions" (Gov't Br. 37), but it acknowledges that some "standard D&Es" will not be excluded by the Act's "anatomical landmark" language. However, the Government fails to meaningfully distinguish between "overt acts" that are permitted because they are "incidental and integral" to the delivery, and those that are banned. *See supra*. Because physicians will have to "guess at [the] meaning" of the Act's language and the Government's strained interpretations, it is unconstitutionally vague. *Smith*, 415 U.S. at 572 n.8.

The Government's second response is to admit that the law is "*broad*," but to argue that its breadth does not make it vague. Gov't Br. 38 (emphasis in original); *see, e.g., id.* at 38 (breadth of phrase "overt act" is "necessary" to capture physicians who perform an "atypical lethal act"), 39 (breadth of phrase "living fetus" is purposefully broad enough to criminalize pre-viability abortions). Notably, the Government admits that the real problem with drafting a precise law is that Congress could not do so *and* "reach[] the full range of conduct" that Congress sought to prohibit, which – by the Government's own admission – includes some disarticulation D&Es. Gov't Br. 38. But, "'[i]t would certainly be dangerous if the legislature could set a net large enough to catch'" physicians performing any D&E, and "'leave it to the courts to step inside' to announce" which D&Es are banned. *Ayotte*, 126 S. Ct. at 968 (quoting *United States v. Reese*, 92 U.S. 214, 221 (1875)).

The Government urges the Court to avoid any constitutional problems resulting from the Act's overbreadth

and vagueness by adopting a narrowing construction that exempts "standard D&Es" from the Act's scope. Gov't Br. 35-36, 39-40. There are numerous problems with this suggestion, starting with the fact that the Government never states explicitly what narrowing construction it proposes, and its "standard D&E" theory is so at odds with the District Court findings and the record that it is certainly not clear on its face. The Government suggests that the limiting construction should be based on defining "standard D&Es" as those ~~in which~~ the lethal act consists of disarticulation that is "incidental and integral" to delivery (and thus is not an "overt act, other than the completion of delivery" within the meaning of the Act). Gov't Br. 32. Yet, in its Brief in *Carhart*, the Government seems to dismiss such an interpretation. Carhart Gov't Br. 47. The disconsonance between the Government's different approaches casts further doubt about what the Act bans, and certainly raises the specter of arbitrary and discriminatory enforcement.

Even if this were the construction the Government means to propose, it is unacceptable because it includes only abortions where the overt act consists of disarticulation, but not those involving other medically appropriate steps, such as compression, decompression, or cutting the umbilical cord (*see* PA 83a), that would cause fetal demise and are "incidental and integral" to completion of the delivery. The Act's language – "performs the overt act, other than completion of delivery, that kills the partially delivered living fetus" (Act § 3(b)(1)(B)) – does not distinguish between types of "overt act[s]." Moreover, there is no constitutional ~~basis for~~ distinguishing among them. Indeed, if the Court construed the Act as exempting "incidental and integral" overt acts consisting of disarticulation, but not consisting of the other methods of completing an abortion when a fetal part obstructs complete extraction, it would push physicians to perform D&Es in a manner that will be

riskier for some women. *Cf.* JA 427, 503-04. Accordingly, the Court should reject the Government's suggestion.

III. THE ACT MUST BE ENJOINED IN ITS ENTIRETY

If this Court finds that the Act fails to meet constitutional standards in any respect, it must decide the appropriate remedy. The Ninth Circuit was correct that a court cannot – consistent with the text of the Act, legislative intent, and the judiciary's limited role – devise a narrow injunction that adequately addresses the Act's constitutional infirmities. PA 40a-54a. Accordingly, the permanent injunction and declaratory judgment facially invalidating the Act must be affirmed.

i. If the Court concludes that the lack of a health exception is unconstitutional, it must – as the Ninth Circuit did – decline to engraft one onto the Act because to do so would "violate the intent of the legislature and usurp the policy-making authority of Congress." PA 41a. In *Ayotte*, this Court concluded that the "touchstone for any decision about remedy is legislative intent." 126 S. Ct. at 968. Here, the legislative history abundantly shows that Congress did not "inten[d]" (*id.*) the Act to have a health exception. PA 42a-45a.

As the Government concedes, Congress rejected several proposals to include a health exception (Gov't Br. 42; *see* PA 43a n. 28; Statement of Case, *supra*), even though they were repeatedly warned by their colleagues that without one, it would violate *Stenberg*. PA 42a n. 27. Indeed, the Act's co-sponsors did not hesitate to show their disdain for a health exception. *See* 149 Cong. Rec. S3486 (daily ed. Mar. 11, 2003) (statement of Sen. Santorum) ("I hope the Justices read this Record because I am talking to you . . . . [T]here is no reason for a health exception."); *see also* ER 1204 (H.R. Rep. No. 108-58 (2003), at 69 (statement of Rep. Chabot)

("[A] health exception, no matter how narrowly drafted, gives the abortionist unfettered discretion in determining when a partial-birth abortion may be performed."); *see generally* PA 42a n. 26, 44a n. 29. Moreover, the Act's findings explicitly state that "a ban on partial birth abortion is not required to contain a 'health' exception." Act § 2(13).

In response, the Government offers two arguments against facial invalidation. First, it argues that "the proponents of the Act would have preferred to prohibit partial-birth abortions in at least some circumstances, even if they could not have prohibited them altogether." Gov't Br. 43 (citing a 1997 statement of Senator Ashcroft, who was not in Congress when the Act was enacted). Yet the record shows that the Senate delayed passage of the Act (in response to a request from the National Right to Life Committee) in an attempt to time the enactment with a potential vacancy on this Court. JA 1052-54. This belies the claim that Congress was interested in preventing as many "partial-birth abortions" as possible. Rather, it suggests that Congress was primarily interested in trying to take advantage of a doctrinal shift on the Court to eliminate the constitutional principle that requires a health exception.

Second, the Government asserts that if the Court cannot determine whether Congress would have preferred no statute to a "modified" one, it should adopt partial invalidation as a default presumption. Gov't Br. 44. This result would conflict with *Ayotte*. While partial invalidation is *preferred*, *Ayotte* does not hold that it is appropriate when, as here, it would conflict with the second and third of the "three interrelated principles." 126 S. Ct. at 967-68.[38]

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[38] If there were to be a default presumption, it should be facial invalidation because Congress can always follow the Court's guidance and re-enact a law that conforms to the Constitution.

The second *Ayotte* principle prohibits courts from rewriting laws to conform to constitutional requirements. *Id.* at 968. Because Congress expressly rejected even a narrow health exception, this Court should not engage in the kind of "inherently complex" "line-drawing" that would be necessary to define the parameters of a health exception, and that *Ayotte* expressly counseled against. *Id.* at 968 (quoting *United States v. Nat'l Treasury Employees Union*, 513 U.S. 454, 479 n.26 (1995) (leaving to Congress the task of drafting a narrower statute "when Congress has sent inconsistent signals as to where the new line or lines should be drawn")).

The third *Ayotte* principle counsels against "circumvent[ing] the intent of the legislature," while being "wary of legislatures who would rely on [the Court's] intervention" to clarify laws that sweep within them constitutionally protected conduct. 126 S. Ct. at 968 (citations and quotation omitted). Even before *Ayotte*, this Court has instructed: "courts 'are not at liberty to create an exception where Congress has declined to do so.'" *Freytag v. Comm'r of Internal Revenue*, 501 U.S. 868, 873-74 (1991) (citation omitted).

Thus, while the Government is correct that the first *Ayotte* principle holds that partial invalidation is the "normal rule," partial invalidation is not proper where, as here, the second and third *Ayotte* principles counsel so strongly against writing in a health exception. Rather, because Congress did not intend the Act to have a health exception, the Act must be facially invalidated.

ii. If the Court concludes that the Act imposes an undue burden because it reaches or chills all D&Es, it should facially invalidate the Act under *Casey* and *Stenberg*. In *Casey*, the Court held that a law that imposes "a substantial obstacle to a woman's choice to undergo an abortion" must be facially invalidated if it so operates "in a

large fraction of the cases." 505 U.S. at 895 (facially invalidating spousal notice provision). In *Stenberg*, although this Court did not use the term "large fraction," it facially invalidated the overbroad Nebraska law because it would unduly burden the rights of women seeking any D&E.

The same is true here. Given that 95% of second-trimester abortions are D&Es, a D&E ban would certainly burden a "large fraction" of affected women. Thus, if the Act took effect, it would cause "[a]ll those who perform" D&Es to "fear prosecution, conviction, and imprisonment." *Stenberg*, 530 U.S. at 945; *cf. Casey*, 505 U.S. at 894.

The Government does not even attempt to explain why – if the Act impermissibly reaches all D&Es – *Stenberg*'s decision to facially invalidate the Nebraska law would not be controlling here. Rather, the Government's sole argument is that this Court should engraft a distinction between so-called "partial-birth abortions" and "standard D&E's" into the Act. Gov't Br. 45. But, as discussed in detail in § II.A.2.b, *supra*, this approach fails. Because the Act implicates all D&Es, it unduly burdens a "large fraction" of affected women and must be facially invalidated.

iii. Facial invalidation is also the appropriate remedy if the Court deems the Act impermissibly vague. *See, e.g., Kolender*, 461 U.S. at 358 n.8, 361-62. As demonstrated in § II.A.2.b, *supra*, a narrowing construction that used the term "standard D&E" would merely propagate the substantive problems with the Act that lead to the need for a remedy in the first place. In other words, it would be no cure at all.

CONCLUSION

For the foregoing reasons, the judgment of the U.S. Court of Appeals for the Ninth Circuit should be affirmed.

Respectfully submitted,

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IN THE

Supreme Court of the United States

ALBERTO R. GONZALES, Attorney General,

Petitioner,

—v.—

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., *et al.*,

Respondents.

(Caption continued on inside cover)

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE* IN SUPPORT OF RESPONDENTS IN RELATED CASE AND BRIEF OF *AMICI CURIAE* RELIGIOUS COALITION FOR REPRODUCTIVE CHOICE AND THIRTY-FOUR OTHER RELIGIOUS AND RELIGIOUSLY AFFILIATED ORGANIZATIONS AND INDIVIDUAL CLERGY AND THEOLOGIANS IN SUPPORT OF RESPONDENTS

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Petitioner,

—v.—

LEROY CARHART, M.D., WILLIAM G. FITZHUGH, M.D., WILLIAM H. KNORR, M.D., and JILL L. VIBHAKAR, M.D., on behalf of themselves and the patients they serve,

Respondents.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE* IN SUPPORT OF RESPONDENTS IN RELATED CASE

On February 21, 2006, this Court granted *certiorari* in *Gonzales v. Carhart*, No. 05-380, to review the judgment of the U.S. Court of Appeals for the Eighth Circuit striking down the Partial-Birth Abortion Ban Act of 2003, Pub. L. No. 108-105, 117 Stat. 1201 ("Act").

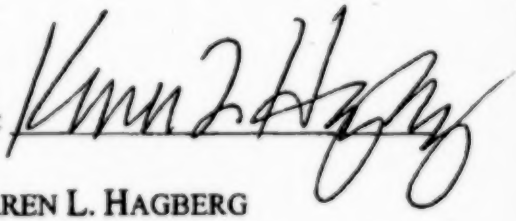
Gonzales v. Carhart raises the same constitutional questions, concerns the same Act of Congress, involves the same petitioner, and will be argued on the same day as the instant case. Furthermore, the information and arguments presented in the brief *amici curiae* are equally relevant to both cases.

Petitioner Gonzales has consented to the filing of this brief *amici curiae* in the instant case, and will not be prejudiced in any way by the granting of this Motion, as Petitioner has the opportunity to respond to this brief in his Reply Brief.

For these reasons, *amici curiae* request that the Court grant them leave to file a jointly-captioned brief in support of respondents, and direct the Clerk to accept this brief out-of-time in *Gonzales v. Carhart*, No. 05-380, and to docket the brief in both cases.

Respectfully submitted,

Dated: September 20, 2006

By: 

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INTEREST OF *AMICI CURIAE*

Amici are religious organizations, religiously affiliated organizations, and individual clergy and theologians dedicated to preserving religious freedom for all persons and, within this context, to ensuring that abortion laws protect a woman's right to act according to her religious beliefs and conscience in this most private, personal decision.[1] The statements of interest provided by individual organizations, representatives, and individuals included in Appendix A to this brief demonstrate the varied and sometimes evolving perspectives on abortion of *amici* and illustrate our point that, for religious reasons that include a responsibility to protect the health of women, many denominations oppose undue restrictions on abortion. Indeed, respect for human life and health is a core value for many religions, including all of the religions represented by *amici*. A full listing of the organizations and individuals signing this brief as *amici curiae* appears in Appendix B.

Because protecting the health of women is a core expression of the religious values of *amici, amici* agree that all women whose health is at risk should be free to seek the safest medical treatment, without governmental coercion or constraint, in making the difficult decision whether to terminate a pregnancy. Other religious traditions and organizations also give primacy to women's health and conscience, as we will show.

---

[1] *Amici* submit this brief *amici curiae* with the consent of the parties. Letters providing consent of the parties are being filed with the Clerk of the Court concurrently with the filing of this brief. Pursuant to Supreme Court Rule 37.6, *amici* state that the brief in its entirety was drafted by *amici curiae* and their counsel. No monetary contribution toward the preparation or submission of this brief was made by any person other than *amici curiae*, their members, or their counsel.

Adherence to these principles, which are based on religious beliefs, compels *amici* to support Respondents in this case.

SUMMARY OF ARGUMENT

As people of faith, *amici* urge the Court to recognize the abundance of religious voices speaking out against the failure of the Partial Birth Abortion Ban Act of 2003 (the "Act") to protect women's health, and not to oversimplify the issue before the Court as one of morality versus immorality. Rather, *amici* urge the Court to heed the mandate of *Casey* "to define the liberty of all, not to mandate [its] own moral code." *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 850 (1992).

Both historically and currently, many religious organizations have given their support to abortion where necessary to protect women's health and, in such circumstances, support a woman's right to the method of abortion that will best protect her health. Internationally, even democracies with either a state religion or a single religious majority have abortion laws that protect women's health. Before this Court's decision in *Roe v. Wade*, 410 U.S. 113 (1973), many Protestant, Jewish, Unitarian Universalist and other clergy and lay people felt it was a religious imperative to support legal abortion as a means of protecting women from dangerous "back alley" procedures. This religious mandate did not end with *Roe*. Rather, many of these religious groups and individuals continue to advocate for legislation that protects women's health.

In light of this diversity of opinion within the U.S. and in the international religious community, *amici* urge the Court not to allow Congress to force a moral consensus, but rather to let the individual women who face the agonizing

decision of whether to terminate a pregnancy or risk their own health do so legally, in consultation and accordance with their own conscience and faith.

ARGUMENT

I. HISTORICALLY, THERE HAS BEEN NO CONSENSUS AMONG AMERICAN RELIGIOUS ORGANIZATIONS CONCERNING REPRODUCTIVE FREEDOM.

It is the position of *amici* that the history of religious conversations on the subject of governmental regulation of reproduction is illuminating and of assistance to this Court. While it may sometimes seem as if a single religious point of view on these matters exists, a historical analysis demonstrates the complexity and multiplicity of religious thought about reproductive rights. Inquiry into two main epochs of transformation in the law of abortion—the time of criminalization efforts during the nineteenth century, and the time around this Court's decision to protect the right of abortion in *Roe*—indicates that public religious discourse on reproductive control has been, alternatively, either notably spare or multiple and plural. Fundamentally, such an inquiry demonstrates that there simply has been no single moral consensus on the issue of reproductive decision-making. And, indeed, while we as Americans may well be familiar with critiques of reproductive rights in the name of religion, it is important to recall that this country has likewise seen defense of these rights by religious institutions that have over time professed their belief in an individual's freedom to exercise her conscience on the matter of abortion.

In the nineteenth century, the medical profession—and not religious groups—spearheaded a movement to expand

the scope of anti-abortion regulation (which had previously permitted abortion prior to fetal quickening). *See* JAMES C. MOHR, ABORTION IN AMERICA: THE ORIGINS AND EVOLUTION OF NATIONAL POLICY, 1800-1900, at 20-45, 147-70 (Oxford University Press 1978); LAURENCE H. TRIBE, ABORTION: THE CLASH OF ABSOLUTES 30-31 (W.W. Norton & Company 1992). The anti-abortion stance of medical practitioners was often grounded in offensive ideology—specifically, in the notion that the prevalence of abortion (particularly among well-to-do American women) was diminishing the native population and thereby threatening the 'ethnic purity' of the nation. *See, e.g.*, HORATIO R. STORER & FRANKLIN FISKE HEARD, CRIMINAL ABORTION: ITS NATURE, ITS EVIDENCE, AND ITS LAW 47-54 (Boston, Little, Brown, and Company 1868).

Generally, "the support offered by organized religion" to the medical community's anti-abortion efforts "was surprisingly limited." MOHR, ABORTION IN AMERICA at 185. Moreover, when some religious persons or groups waded into the anti-abortion discourse, they often invoked the same offensive ideological reasoning as physicians did. For example, the sparse public opposition to abortion by Protestant clergy carried nativist undertones, and was an outgrowth of fear of population decline relative to growing *Catholic* communities. *See, e.g.*, HORACE KNAPP, WOMAN'S CONFIDENTIAL ADVISER ON THE HEALTH AND DISEASES OF WOMEN 78-79 (Providence 1873).

While in the 1800s religious groups had remained for the most part disengaged from the campaign to expand the illegality of abortion, just prior to this Court's decision in *Roe* they were relatively vocal about the abortion issue. But, it is important to note, around the time of *Roe* there was no straightforward or easy consensus on reproductive

rights. Indeed, some religious groups (even prior to *Roe* and in the face of abortion's illegality) argued for reproductive freedom. These arguments were based on at least two principles: the sanctity of the life and health of the woman in the face of dangerous and illegal abortion procedures; and this nation's founding principle of religious freedom and the right to act according to one's own moral judgment.

The most noteworthy example of religious support for legal abortion came in 1967 (six years before this Court's watershed decision protecting the abortion right), when twenty-two clergy founded the Clergy Consultation Service on Abortion. *See* DAVID P. CLINE, CREATING CHOICE: A COMMUNITY RESPONDS TO THE NEED FOR ABORTION AND BIRTH CONTROL, 1961-1973, at 5-7 (Palgrave Macmillan 2006); TOM DAVIS, SACRED WORK: PLANNED PARENTHOOD AND ITS CLERGY ALLIANCES 2-3 (Rutgers University Press 2005).

In the years prior to *Roe*, women seeking to have abortions faced substantial dangers to their lives and health. Strikingly, pre-*Roe*, illegal abortions resulted in approximately 100,000 hospital admissions annually (for complications such as hemorrhaging). Theodore Irwin, *The New Abortion Laws: How Are They Working?*, TODAY'S HEALTH, Mar. 1970, at 21, 21. And, during this time, abortions were the "major cause" of maternal death. *Id.* For example, by the early 1960s, although they "were almost completely preventable," "abortion-related deaths accounted for nearly half, or 42.1 percent, of . . . total maternal mortality" in New York City. LESLIE J. REAGAN, WHEN ABORTION WAS A CRIME: WOMEN, MEDICINE, AND LAW IN THE UNITED STATES, 1867-1973, at 211, 214 (University of California Press 1997). In the face of these

significant dangers from illegal abortions, many clergy were motivated to act to protect women's lives and health.

The Clergy Consultation Service on Abortion sought to protect women by offering counseling and making abortion referrals to safe practitioners. Participating clergy expressed their concern for women in the Service's statement of purpose:

> The present abortion laws require over a million women in the United States each year to seek illegal abortions which often cause severe mental anguish, physical suffering, and unnecessary death of women. . . .
>
> Belief in the sanctity of human life certainly demands helpfulness and sympathy to women in trouble. . . .
>
> Therefore believing as clergymen that there are higher laws and moral obligations transcending legal codes, we believe that it is our pastoral responsibility and religious duty to give aid and assistance to all women with problem pregnancies.

DAVIS, SACRED WORK at 129 (quoting HOWARD MOODY & ARLENE CARMEN, ABORTION COUNSELING at 30-31 (Judson Press 1973)).

As the Service's mission statement suggests, by the time of *Roe*, a significant inversion had taken place. If in the nineteenth century a woman's body had been perceived as an object to be regulated for the purpose of protecting the presumed 'ethnic integrity' of the body politic, during the pivotal time around *Roe* a train of religious discourse

attended to women's own *physical suffering*—and to the corresponding urgency of liberalizing abortion laws.

Finally, in the time of *Roe*, the desire to protect women did not alone motivate clergy. The clergy also advocated in favor of the legality of abortion on the basis of this nation's fundamental guarantee of religious freedom and in the name of religious pluralism. As E. Spencer Parsons, a minister who served as Chairman of the Chicago Clergy Consultation Service on Problem Pregnancies, stated in a 1971 address:

> Physicians, social workers and clergymen should enjoy the freedom of being able to give counsel and information on matters of family health and welfare without being subject to arrest for conspiring to commit an illegal act which is morally a matter of private conscience . . . .
>
> [S]ince we are a people representing many diverse religious traditions, is it not the best public policy, out of respect for our different convictions on the matter, for the State to withdraw from regulating this area of human intimacy?

E. Spencer Parsons, *Abortion: A Private and Public Concern*, 10 CRITERION 2 (Winter 1971).

In sum, far from being in agreement as to the morality of abortion, members of the religious community have held diverse views on the issue historically, and a number of groups have worked to perfect reproductive freedom.

II. THERE IS NO CONSENSUS TODAY AMONG RELIGIOUS COMMUNITIES THAT ABORTION REGULATIONS SHOULD NOT PROTECT THE HEALTH OF THE WOMAN.

Religious communities today represent a diversity of opinion as to the question currently before the court—*i.e.*, whether an exception for the health of the woman is required for legislation criminalizing abortion procedures that many doctors believe are the safest for some women.[2] Many Protestant, Jewish, and Unitarian Universalist organizations support a woman's right to make a decision about abortion in consultation with her doctors and without undue government interference; many others support abortion where necessary to preserve the life or health of the woman. In fact, in recent years in the United States, these groups and individuals have actively fought against legislation—such as the Act—that fails to protect the life or health of the woman.

This plurality of religious opinion is a testament to the intensely personal nature of the decision to terminate a pregnancy. The Act, which strips women of the ability to make crucial decisions about their health and well-being in consultation with their doctors, is an undue government intrusion into a woman's personal, religious, or moral sphere.

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[2] The Act at issue bans procedures from as early as 12 to 14 weeks gestation.

A. Many Religions Support A Woman's Right To Make Reproductive Decisions Without Government Interference.

For many people of faith, freedom to make decisions of conscience without government interference is consistent with their deeply held religious convictions. The Central Conference of American Rabbis, for example, has reaffirmed that the "decision concerning any abortion must be made by the woman and not by the state or any other external agency." 91st Annual Convention of the Central Conference of American Rabbis Pittsburgh Pennsylvania, June 23-26, 1980 (on file with Religious Coalition for Reproductive Choice ("RCRC")).

The Episcopal Church has stated its "unequivocal" opposition to any government act that "abridges the right of a woman to reach an informed decision about the termination of pregnancy." General Convention Statement on Childbirth and Abortion, *Journal of the General Convention of the Episcopal Church 1994*, at 324 (General Convention 1995), *available at* http://www.episcopalarchives.org/cgi-bin/acts_new/acts_resolution-complete.pl?resolution=1994-A054 [hereinafter *1994 General Convention Statement*].

While in 1997 the 72nd General Convention of the Episcopal Church expressed "grave concern" about the use of the "intact dilation and extraction" procedure—which is only one of the procedures banned by the Act—in the third trimester of pregnancy, it made an exception for "extreme situations." It did not change its comprehensive 1994 resolution opposing "any legislative, executive or judicial action limiting decision-making on or access to abortion." General Convention, *Journal of the General Convention of . . . The Episcopal Church, Philadelphia, 1997*, at 270

(New York: General Convention, 1998), *available at* http://www.episcopalarchives.org/cgi-bin/acts/acts_resolution.pl?resolution=1997-D065.

Additionally, the General Convention stated in 1994,

> We therefore express our deep conviction that any proposed legislation on the part of national or state governments regarding abortions must take special care to see that the individual conscience is respected, and that the responsibility of individuals to reach informed decisions on this matter is acknowledged and honored as the position of this Church.

1994 General Convention Statement, at 324.

The Evangelical Lutheran Church in America stated that "there can be sound reasons for ending a pregnancy through induced abortion. . . . We recognize that conscientious decisions need to be made in relation to difficult circumstances that vary greatly." Churchwide Assembly on the Evangelical Lutheran Church in America, *Social Teaching Statement on Abortion* (1991), *available at* http://www.elca.org/socialstatements/abortion.

Recognizing the plurality of opinion on the issue of abortion even within its own membership, the Presbyterian Church (USA) ("PCUSA") stated that, " the decision regarding abortion must remain with the individual, to be made on the basis of conscience and personal religious principles, and free from governmental interference." *Covenant and Creation: Theological Reflections on Contraception and Abortion, Minutes of the 195th General*

Assembly of the Presbyterian Church, at 369 (1983) (on file with RCRC).

This Church's current statement recognizes the "intensely personal" nature of the decision to terminate a pregnancy and the role religion must play in that decision:

> Humans are empowered by the spirit prayerfully to make significant moral choices, including the choice to continue or end a pregnancy. Human choices should not be made in a moral vacuum, but must be based on Scripture, faith, and Christian ethics. For any choice, we are accountable to God; however, even when we err, God offers to forgive us.

PCUSA, *Statement on Post-Viability and Late-Term Abortion* (2006), *available at* http://www.pcusa.org/overture2004-10/postviabilitystatement.pdf.

The National Association of Evangelicals, which "deplores in the strongest possible terms" legalization of abortion for "personal convenience or sociological considerations," nevertheless has held a position since 1973 that states:

> At the same time, we recognize the necessity for therapeutic abortions to safeguard the health or the life of the mother, as in the case of tubular pregnancies. Other pregnancies, such as those resulting from rape or incest may require deliberate termination, but the decision should be made only after there has been medical, psychological and religious counseling of the most sensitive kind.

National Association of Evangelicals, *Abortion* (1973), *available at,* http://www.nae.net/index.cfm?FUSEACTION=editor.page&pageID=154&IDCategory=9.

B. Many Religions Support Abortion Where Necessary To Protect The Life Or Health Of The Woman.

Respect for human life and health is a core value for many religions, including all of the religions represented by *amici*. For some faiths, this value is paramount and *requires* that a woman be able to obtain an abortion when her health or life is at risk. For other faiths, a woman considers her health as one of several factors in making her personal decision about her pregnancy. For women of all of these faiths, restrictions on access to abortion (and, in particular, criminal statutes) that do not provide an exception for the health of the woman not only risk women's health but threaten their religious values.

The PCUSA offered another view in its official statement issued in 2006. The statement underscores the complexity of religious and moral views about abortion as individuals and denominations seek to discern God's will and to consider the life and health of both the woman and her fetus:

> In cases where problems of life or health of the mother arise in a pregnancy, the church supports efforts to protect the life and health of both the mother and the baby. When late-term pregnancies must be terminated, we urge decisions intended to deliver the baby alive.

217th General Assembly of PCUSA, *Overture 26 On Late-Term Pregnancy* (2006), *available at* http://www.pcusa.org/ga217/business/overtures/ovt2605.htm.

The United Methodist Church, recognizing the "tragic conflicts of life with life" that certain women face, has concluded that "continuance of a pregnancy which endangers the life or health of the mother, or poses other serious problems concerning the life, health, or mental capability of the child to be, is not a moral necessity. In such cases, we believe the path of mature Christian judgment may indicate the advisability of abortion." THE BOOK OF RESOLUTIONS OF THE UNITED METHODIST CHURCH 44, 129 (The United Methodist Publishing House 2004) (on file with RCRC).

Speaking specifically to the intact dilation and extraction procedure (which is only one of the procedures banned by the Act), the United Methodist Church's position states, "We oppose the use of late-term abortion known as dilation and extraction (partial-birth abortion) and call for the end of this practice except when the physical life of the mother is in danger and no other medical procedure is available, or in the case of severe fetal anomalies incompatible with life." *Id.* at 161. Thus, the United Methodist Church, while clearly concerned about the moral implications of intact dilation and extraction, supports exceptions for severe fetal anomalies incompatible with life and for certain circumstances when no other procedure is available; both of these exceptions are missing from the Act.

For many Jewish women, access to abortion where necessary to protect the life or health of the woman is a religious dictate. The United Synagogue of Conservative

Judaism stated in 1991 that, "under special circumstances, Judaism chooses and requires abortion as an act which affirms and protects the life, well being and health of the mother. . . ." *United Synagogue of Conservative Judaism Resolution on Abortion*, Passed at 1991 Biennial Convention, *available at* http://www.uscj.org/SocPolAbortion_Contr5481.html.

For women of faiths that encourage prayerful consideration of a woman's health, or in fact mandate that a woman's health be preserved, the Act's lack of a health exception is religiously intolerable. The Act leaves no room for such women to make highly personal decisions about their health in consultation with their faith and in accordance with their religious values. Rather, the Act legislates *one* moral path as *the* path for all women.

C. Many Religious Organizations And Individuals Have Fought *Against* Legislation That Risks Women's Health.

Religious groups and people of faith have consistently fought against abortion legislation that threatens the health of the woman.

The Religious Coalition for Reproductive Choice, which represents a great diversity of religious and theological organizations, institutions, and individuals, has fought vigorously at both the state and federal level to uphold *Casey* and ensure that abortion regulations protect the life and health of the woman, including the ability to obtain procedures that physicians believe best protect a woman's health. *See, e.g.*, RCRC, *Our Mission: A Message from Reverend Carlton W. Veazey, President and CEO*, *available at* http://www.rcrc.org/about/index.cfm; RCRC, *Statement of the Board of Directors on Campaign*

to Ban Abortion and "Partial-Birth Abortion Ban Bill" (June 4, 2003) (on file with RCRC); *Letters from RCRC to U.S. Senators* (Sept. 17, 1998) (on file with RCRC); *Letter from RCRC to President William Jefferson Clinton* (Apr. 29, 1996) (on file with RCRC) [hereinafter *1996 RCRC Letter to President Clinton*].

In 1996, seventy-one Protestant, Jewish, Unitarian Universalist, and other religious leaders signed a letter of support for President Clinton's veto of Congressional legislation that would have banned the dilation and extraction procedure, without exception for the life or health of the woman. The letter set forth the religious leaders' conviction

> that each woman who is faced with such difficult moral decisions must be free to decide how to respond, in consultation with her doctor, her family, and her God. Neither we as religious leaders, nor the president, nor Congress—none of us—can discern God's will as well as the woman herself. . . .

1996 RCRC Letter to President Clinton; *see also* Laurie Goodstein, *Religious Leaders Back Abortion Ban Veto*, The Washington Post, Apr. 30, 1996, at A4 (noting close to thirty original signatories to letter).

Individual women of different faiths also stepped forward in support of President Clinton's 1996 veto by sharing publicly their agonizing decisions, when faced with grave threats to their health and hopeless diagnoses for the fetuses they were carrying, to undergo the intact D&E procedure, which would be banned by the Act. President William Jefferson Clinton, *Remarks by the President on House Resolution 1833* (Apr. 10, 1996) (on file with RCRC).

Among them was Coreen Costello, who described herself and her husband as "very, very much pro-life, conservative Republicans." *Id.* at 3. Mrs. Costello learned when she was seven months pregnant that the fetus she was carrying was suffering from polyhydramnia, which also severely threatened Mrs. Costello's health. Mrs. Costello explained her painful decision about her daughter:

> She was dying and she would likely not survive any labor and there was no way I could deliver her. We had her baptized in utero. We named her Katherine Grace. We then realized that our only safe option was the procedure that . . . is being attempted to be outlawed.

Id.

Mary-Dorothy Line, who described herself and her husband as "practicing Catholics," shared how she learned, nineteen weeks into her pregnancy, that the fetus she was carrying had hydrocephalus, and how she had no option but to terminate the pregnancy.

> This was not our choice, for not only was our son going to die, but the complications of the pregnancy put my health in danger, as well. If I carried to term, he might die in utero, and the resulting toxins could cause a hemorrhage and possibly a hysterectomy. The hydrocephaly also meant that a natural labor risked rupturing my cervix and my uterus.

Id. at 2.

In 1998, notwithstanding the efforts of these religious individuals and organizations, a bill similar to that vetoed

by President Clinton in 1996 was introduced and passed in both the Senate and House of Representatives. President Clinton vetoed the 1998 bill, again citing its lack of an exception to protect the life or health of the woman. And, again, religious groups supported the President's veto.

For example, the Office for Church and Society of the United Church of Christ fought to sustain President Clinton's 1998 veto, by stating to the United States Senate the "overwhelming religious consensus within our church":

> Let the church and the religious community offer its advice on this issue, advice to the women facing the choice. Let the medical community offer its advice. But keep the government out of it. Protect the fundamental religious responsibility of a woman to make this decision about her own body and her own responsibility for the developing life within her.

Rev. Dr. Jay Lintner, *Statement on Partial-Birth Abortions Urging the Senate To Sustain President Clinton's Veto of H.R. 1122* (Sept. 17, 1998) (on file with RCRC).

Mark J. Pelavin, Associate Director of the Religious Action Center of Reform Judaism, issued a statement on September 17, 1998, on behalf of 870 congregations, 1,880 rabbis, and 1.5 million Reform Jews in support of President Clinton's veto. The statement read, in part, "Women are capable of making moral decisions, often in consultation with their clergy, families and physicians, on whether or not to have an abortion. We believe that religious matters are best left to religious communities, not politicians." Press Release, Religious Action Center of Reform Judaism, Statement of Mark J. Pelavin (Sept. 17, 1998) (on file with RCRC).

Claudia Crown Ades, a Jewish woman, shared the "spiritual journey" that started when she learned that the fetus she was carrying had the fatal chromosomal disorder Trisomy 13, and that the pregnancy posed a serious threat to her health, as well. Press Release, RCRC, Statement of Claudia Crown Ades (Sept. 17, 1998) (on file with RCRC).

> Our baby's brain was filled with fluid that prevented further development. He had a seriously malformed heart with a hole between the chambers hindering normal blood flow. A giant cyst, filled with intestinal matter, formed on the outside of his chest. He had hyperteloric eyes and much, much more. Our baby stood zero chance of survival.

Id.

In consultation with her doctors, her family, and God, Mrs. Ades decided to terminate her pregnancy to preserve her health and end the suffering of the fetus she was carrying. For her, it was a religious decision: "I believe that my instinct [to request an unscheduled ultrasound] was God's way of letting me know that my son wasn't meant to come into this world and that he was suffering inside me and dying. God showed me a way to end his suffering." *Id.*

In 2001, Maureen Mary Britell, a Catholic woman who, before 1994, "never thought I could imagine a reason why a woman would ever have an abortion," shared her agonizing story in a letter to members and supporters of the National Abortion Federation. *Letter from Maureen Mary Britell* (June 12, 2001) (on file with RCRC). In 1994, five months into her pregnancy, Mrs. Britell discovered that the fetus she was carrying suffered from the fatal anomaly anencephaly and had developed a brain stem but no brain.

Id. In order to protect Mrs. Britell's health, the doctors recommended an induction abortion whereby Mrs. Britell's labor would be induced and the umbilical cord cut upon delivery, thus allowing the fetus to die after delivery. *Id.* Mrs. Britell wrote about how she struggled with the decision:

> I am a Catholic and the idea of ending my pregnancy was beyond my imagination. I turned to my parish priest for guidance. He counseled me for a long time, and in the end, he agreed that there was nothing more I could do to help my daughter. With the support of our families and our priest, [my husband] and I made the decision to end the pregnancy.

Id.

Mrs. Britell's doctors induced her labor as planned, but there were complications, and the doctors had to cut the umbilical cord while the fetus was still in the birth canal, in order to avoid serious health complications for Mrs. Britell. This "partial birth abortion" was necessary to preserve Mrs. Britell's health, and it would be outlawed under the Act. *Id.*

In each of these instances, religious organizations, leaders, and individuals fought against legislation which did not adequately safeguard the lives and health of women, and they did so in consultation with—and in many cases compelled by—their religious beliefs.

D. Many Religious Democracies Abroad Recognize The Importance Of Safeguarding Women's Health.

This Court has often looked to the experiences of other nations to illuminate the nature of individual rights. *See, e.g., Roper v. Simmons*, 543 U.S. 551, 576 (2005) (citing global condemnation of capital punishment for juvenile offenders); *Lawrence v. Texas*, 539 U.S. 558, 573 (2003) (citing European and British law to clarify the values of Western civilization and of Judeo-Christian moral and ethical standards). Of particular significance here is the fact that many democracies with either a state religion or a strong religious majority have enacted abortion laws with exceptions to protect the health of the woman.

According to a study by the United Nations of abortion law and policy, Protestant and Orthodox Christian countries overwhelmingly approve of protecting the health and life of the pregnant woman. U.N. Dep't of Econ. & Soc. Affairs Population Div., Abortion Policies A Global Review Volume I Afghanistan to France, U.N. Doc. ST/ESA/SER.A/187, U.N. Sales No. E.01.XIII.10 (2001); U.N. Dep't of Econ. & Soc. Affairs Population Div., Abortion Policies A Global Review Volume II Gabon to Norway, U.N. Doc. ST/ESA/SER.A/191, U.N. Sales No. E.01.XIII.18 (2001); U.N. Dep't of Econ. & Soc. Affairs Population Div., Abortion Policies A Global Review Volume III Oman to Zimbabwe, U.N. Doc. ST/ESA/SER.A/196, U.N. Sales No. E.02.XIII.5 (2001). Available at http://www.un.org/esa/population/publications/abortion/ [hereinafter *United Nations Study*].

The law of the United Kingdom permits abortion after 24 weeks gestation to protect the health or life of the

woman, or if the fetus is severely handicapped. Human Fertilisation and Embryology Act, 1990, c. 37, § 37 (U.K.). The Church of England has stated that "there can be strictly limited conditions under which [abortion] may be morally preferable", and Anglicans "may come to different conclusions about the proper course of action in particular cases." The Church of England, *Abortion: A Briefing Paper*, (2005), *available at* http://www.cofe.anglican.org/info/socialpublic/abortion.html.

Furthermore, despite the Vatican's comprehensive ban on abortion, the majority of Catholic countries permit abortion when it is necessary to protect the health or life of the pregnant woman.[3] *See, e.g.*, Gazz. Uff. Della Repubblica Italiana, Part I, 2 May 1978, No. 140, pp. 3642-3646 (Italy) (abortion may be performed after the first 90 days if a serious threat to the woman's physical or mental health has been diagnosed); Law No. 11179, 21 December 1984, Cód. Pen., Artículo 86 (Arg.) (although generally prohibited, abortion to prevent harm to the woman's life or health is not punishable); *see generally United Nations Study*; Harvard Law School, *Abortion Laws of the World*, Annual Review of Population Law, http://annualreview.law.harvard.edu/annual_review.htm (last visited Aug. 11, 2006).

Israel also approves of abortion on broad medical grounds, including the protection of the health or life of the woman. *United Nations Study*. And eleven Islamic nations (Algeria, Azerbaijan, Bahrain, Jordan, Kyrgyzstan, Malaysia, Morocco, Tajikistan, Tunisia, Turkmenistan and

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[3] The laws of Argentina, Bolivia, Costa Rica, Guatemala, Italy, Liechtenstein, Luxembourg, Panama, Peru, Portugal and Spain protect both the health and life of the woman.

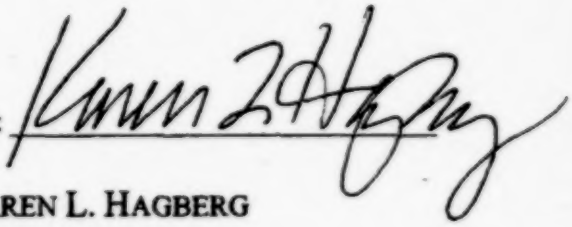
Uzbekistan) permit abortions to protect the health or life of the pregnant woman. *Id.*

These countries represent a diversity of political and religious positions, but they share an ability to integrate principles of faith with a state interest in regulating abortion in such a way as to protect both the health and the life of a pregnant woman.

CONCLUSION

For the foregoing reasons, the Court should affirm the decisions of the United States Courts of Appeal for the Eighth and Ninth Circuits.

Dated: September 20, 2006

By: 

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APPENDIX A: STATEMENTS OF INTEREST OF THE *AMICI CURIAE*

AMERICAN JEWISH COMMITTEE

The American Jewish Committee (AJC), a national organization of approximately 150,000 members and supporters, was founded in 1906 to protect the civil and religious rights of Jews. AJC believes that this goal can best be achieved by preserving the constitutional rights of all Americans, including the fundamental right of access to abortion. For this reason, AJC firmly believes that when faced with reproductive health decisions – often in the context of wanted pregnancies gone tragically wrong – women and their families, in consultation with their doctors and in accordance with their religious beliefs, must be able to choose the medical procedure that is safest for the woman and best protects her ability to bear future children.

AMERICANS FOR RELIGIOUS LIBERTY

Americans for Religious Liberty (ARL) is a nonprofit interfaith educational organization, founded in 1982, to defend church-state separation, freedom of conscience, and reproductive choice. ARL has been before this Court numerous times as an *amicus*, including in cases defending reproductive choice.

ANTI-DEFAMATION LEAGUE

The Anti-Defamation League (ADL), founded in 1913, is a national Jewish human relations organization dedicated to

principles of religious and individual liberty, including the right to privacy. ADL views reproductive choice as an issue of personal and religious freedom. Accordingly, ADL believes that a woman's right to make her own decision concerning abortion is constitutionally protected and should be made in accordance with her own religious and moral convictions, without governmental intrusion. ADL has participated as *amicus curiae* in numerous cases before the Supreme Court and other courts when these issues have been implicated, including *Ayotte v. Planned Parenthood of Northern New England* (2006); *Stenberg v. Carhart* (2000); *Planned Parenthood v. Casey* (1992); and *Webster v. Reproductive Health Services* (1989).

DISCIPLES FOR CHOICE

Disciples for Choice is an organization of members of the Christian Church (Disciples of Christ) who support reproductive choice. The organization endeavors to maintain the freedom of every woman to decide when to bear children according to her own conscience and religious belief, without governmental interference. Disciples for Choice holds high the dignity of women as responsible decision makers. It also recognizes the diverse approaches to the issue of reproductive choice among faith groups and religious denominations. The spectrum of views as to when abortion may be morally justified supports the conviction that the individual must make the abortion decision utilizing the guidance of personal faith and counsel.

DISCIPLES JUSTICE ACTION NETWORK

Disciples Justice Action Network (DJAN), founded in 1996 in Chicago, Illinois, is a 501(c)(3) tax-exempt organization. DJAN counts some 2,000 supporters and its fast-growing constituency is made up of churches, other justice issue groups and individuals. DJAN strongly supports women's reproductive rights. The Gospel envisions a society in which all are free from oppression, despair, poverty, violence and marginalization. Women's lives and health must be given paramount consideration in abortion-related decisions. Banning abortion procedures with no exception for the health of the woman would conflict with DJAN's religious principals and values.

EPISCOPAL WOMEN'S CAUCUS

The Episcopal Church, acting through its legislative body, the General Convention, has on numerous occasions since 1967 affirmed the right of every pregnant woman, preferably in consultation with a member of the clergy, to make her own decision about whether to carry a pregnancy to term and has unequivocally opposed legislative efforts to curtail that right.

The Episcopal Women's Caucus concentrates its efforts on promoting a Church that honors and rejoices in the ministries of all women, which would result in a Church that honors and rejoices in the ministries of all people. One aspect of its work is giving visibility and respect to women's perspectives and actions in the work and struggle for justice, peace and the integrity of creation. The

Episcopal Women's Caucus strongly opposes the restriction under review in this case.

HADASSAH, THE WOMEN'S ZIONIST ORGANIZATION OF AMERICA

Hadassah, the Women's Zionist Organization of America, founded in 1912, is the largest women's and Jewish membership organization in the United States, with over 300,000 members nationwide. In addition to Hadassah's mission of maintaining health care institutions in Israel, Hadassah has a proud history of protecting the rights of women and the Jewish community. Hadassah is one of the nation's preeminent advocates of women's health issues. Hadassah has a longstanding commitment to staunchly supporting and working to protect a woman's right to choose abortion and other reproductive health care services. Hadassah regards reproductive freedom as a right protected by the First Amendment, which guarantees freedom of religion – the freedom to consult one's own religious beliefs in making a personal choice, free from government interference

JEWISH RECONSTRUCTIONIST FEDERATION

Founded in 1955, the Jewish Reconstructionist Federation (JRF) is the rapidly growing synagogue arm of the Reconstructionist movement, serving 107 congregations and havurot spread across North America. A voice of Reconstructionist Judaism in the greater Jewish world, JRF provides a wide array of services to its affiliates. People experience Reconstructionist congregations as open, inclusive, and egalitarian, both in principle and in practice.

APPENDIX A (continued)

JRF-affiliated communities are autonomous, progressive, and democratic.

Updated from the JRF 1981 statement in support of the Religious Coalition for Reproductive Choice, an organization that JRF is officially affiliated with:

Although the Jewish tradition regards children as a blessing, a gift of life itself, the tradition permits the abortion of an unborn child in order to safeguard the life and physical and mental health of the mother. The rabbis did not take a consistent stand on the question of whether a fetus resembles a "person". They did not think it possible to arrive at a final theoretical answer to the question of abortion, for that would mean nothing less than to be able to define convincingly what it means to be human.

We recognize that abortion is a painful choice. Any prospective parent must make an agonizing decision between competing claims- the fetus, health, the need to support oneself and one's family, the need for time for a marriage to stabilize, responsibility for other children and the like.

Reconstructionist Judaism recognizes that we live in both religious and civic cultures simultaneously. The law of the United States of America supports a woman's right to obtain an abortion, although limitations and restrictions have been applied. The JRF likewise supports the preservation and protection of the reproductive rights of women, and the individual right of women to make the painful decision to abort or not to abort.

JUSTICE AND WITNESS MINISTRIES OF THE UNITED CHURCH OF CHRIST

The United Church of Christ, through its primary representative policy-setting body, the General Synod, has since 1971 supported resolutions affirming the legalization of abortion; providing access to full reproductive services, including abortion and information about contraception, for all women regardless of income; and reaffirming support for *Roe v. Wade*. These resolutions have been affirmed by the General Synod in 1971, 1973, 1977, 1979, 1981, 1987 and 1989. We have based these resolutions on our support for life and the sacredness of life while at the same time recognizing that complex circumstances can be present which can create moral, ethical and religious conflict. Making critical decisions in regards to unintended pregnancies must be primarily the decision of the woman who is pregnant who must wrestle with her religious beliefs, and moral and ethical values.

Justice and Witness Ministries of the United Church of Christ joined an amicus curiae in the case of *Stenberg v Carhart,* and join this brief for the same reasons. We recognize that the health of a woman who faces life-threatening conditions during the third trimester of pregnancy should the pregnancy be allowed to continue is of paramount importance. The decision about what appropriate medical intervention, if any, should be taken must be made by the woman and her physician. The decision about what procedure to use, should intervention be called for, must be the decision of the physician whose primary responsibility is to safeguard the life and health of the patient. No law should restrict a doctor from

recommending the safest, most medically appropriate procedures.

METHODIST FEDERATION FOR SOCIAL ACTION

The Methodist Federation for Social Action has been in existence since 1907. We have 2,800 members in 34 chapters and are an independent, nation-wide network of United Methodists committed to providing a fruitful witness to the Gospel of Jesus Christ, working primarily through the ministries of the United Methodist Church. Our members work on a wide variety of peace and justice issues including religious liberty, promotion of human rights, non-discrimination, and the empowerment of women. We support reproductive choice.

We affirm the goodness of God's creation and the sacredness of all creation. Therefore, we do not take the question of abortion lightly. We long for a world where abortion is unknown. We envision a world where every child is a wanted child; where family planning and birth control are readily available to and practiced by all the peoples of the world; where adequate nutrition, medical, spiritual, emotional and psychological care is available to all; where meaningful employment and the means to support oneself and one's family are universal; and where adequate prenatal, perinatal, maternal, and child care is available to all. We also recognize that in an imperfect world these goals will never be fulfilled equitably for all people.

Because we regard all life as sacred, we regard the life and well being of the mother-to-be as just as valuable as the

potential life of the fetus. We recognize that there are many situations in which more than one of our most deeply held religious and moral values about the sacredness of life will come into conflict with each other. And we recognize that only the individuals most intimately involved in a crisis pregnancy can adequately weigh the factors and values in conflict and come to a decision about the most appropriate course of action. In view of this, we support the right of a woman to choose whether to carry her pregnancy to term, keep her child, give her child up for adoption, or terminate her pregnancy.

The right of reproductive freedom is an issue of religious liberty. Different religious traditions hold widely differing positions on issues related to birth control, pregnancy, abortion, and other issues of reproductive freedom. Because we are guaranteed religious freedom in our Constitution, we believe that reproductive issues must remain free from government interference. We believe that for secular authority to codify any particular religious tradition or position into law is a violation of the religious liberty of all religious traditions whose teachings differ from that law.

NATIONAL COUNCIL OF JEWISH WOMEN

The National Council of Jewish Women, Inc. (NCJW) is a volunteer organization, inspired by Jewish values, that works to improve the quality of life for women, children, and families, and to ensure individual rights and freedoms for all through its network of 90,000 members, supporters, and volunteers nationwide. NCJW endorses the protection

of every female's right to reproductive choice, including safe and legal abortion, and the elimination of obstacles that limit reproductive freedom. In addition, we believe that religious liberty and the separation of religion and state are constitutional principles that must be protected and preserved in order to maintain our democratic society. Consistent with our priorities and resolutions, NCJW joins this brief.

THE RABBINICAL ASSEMBLY

The Rabbinical Assembly is the international association of Conservative rabbis founded in 1901. Rabbis of the Assembly provide religious leadership for the Conservative movement and serve throughout the world. The Assembly shapes the ideology and practices of the Conservative movement, and administers the work of the Committee on Jewish Law and Standards for the Conservative movement. In 2001, our Law Committee issued a responsum written by Rabbi Avram I. Reisner, ruling that partial-birth abortion is forbidden according to Jewish Law except in the most dire of circumstances. Between the forces of choice who would grant every woman the freedom to abort at will and those pro-life forces who would define life as beginning at conception and ban abortion completely, halakhah (Jewish Law) has championed a bright line conception whereby life begins at birth, but abortion proceeds only for good and sufficient cause. The task of the CJLS is to rule for Jewish women and Jewish practitioners, not to rule for America.

UNION FOR REFORM JUDAISM

The Union for Reform Judaism (Union), founded in 1873, is the central body of the Reform Movement in North America including 900 congregations encompassing 1.5 million Reform Jews. The Union comes to this issue out of our strong belief in the right of a woman to act in accordance with the moral and religious dictates of her conscience with respect to abortion. While recognizing the right of religious groups whose beliefs differ from ours to follow the dictates of their faith in this matter, we vigorously oppose the attempts to legislate the particular beliefs of those groups into the law that governs us all. Our tradition has always upheld the sacredness of life. Similarly it has upheld the sacredness of the body. Sensitive medical decisions should remain in the hands of women, in consultation with their doctors and on the basis of their own beliefs, without interference from those with political agenda in opposition to established rights. The Reform Jewish Movement opposes laws which would prevent women from choosing to access safe and potentially life-saving medical treatment.

UNITED SYNAGOGUE OF CONSERVATIVE JUDAISM

As affirmed in our 1991 resolution and reaffirmed in 2005, a woman's life and health may mandate the early termination of pregnancy according to Jewish law as determined by the Committee on Jewish Law and Standards (CJLS) and the local rabbinic authority. The United Synagogue of Conservative Judaism supports legislation maintaining the legality and accessibility of

abortion so that in those cases where our religious authorities determine that an abortion is warranted halakhically, obtaining that abortion will not be hindered by our civil law. The United Synagogue of Conservative Judaism opposes any legislation in the United States or Canada that will hinder an individual's ability to meet a halachic obligation in regard to abortion.

WOMEN OF REFORM JUDAISM

Women of Reform Judaism (WRJ), an affiliate of the Union for Reform Judaism, is the collective voice and presence of women in congregational life. Stronger together, we support the ideals and enhance the quality of Jewish living to ensure the future of progressive Judaism in North America, Israel and around the world. Including over 75,000 women in 500 local groups nationwide, WRJ is deeply committed to the social justice teachings of the prophets and the concept of *pikuach nefesh* – the "value of life." Serving humanitarian causes, WRJ has adopted resolutions in support of reproductive rights in 1975, 1977, and 1989, and in 1991 WRJ called for support of legislation to provide universal access to health care, including all aspects of reproductive health care, regardless of age and economic status. WRJ has advocated the right of individual women to make decisions regarding abortion based on their conscience and religious beliefs and has opposed efforts, such as the so-called partial birth abortion ban, to redefine or curtail those rights.

APPENDIX B: List of Amici Curiae

American Jewish Committee

Americans For Religious Liberty

Anti-Defamation League

Disciples For Choice

Disciples Justice Action Network

Episcopal Women's Caucus

Hadassah, The Women's Zionist Organization Of America

Jewish Reconstructionist Federation

Justice And Witness Ministries Of The United Church Of Christ

Methodist Federation For Social Action

National Council Of Jewish Women

The Rabbinical Assembly

Union For Reform Judaism

United Synagogue Of Conservative Judaism

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* For identification purposes only.

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In The

Supreme Court of the United States

ALBERTO R. GONZALES, U.S. Attorney General,

Petitioner,

vs.

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., ET AL.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

AMICUS CURIAE BRIEF OF RIGHT TO LIFE ADVOCATES, INC. IN SUPPORT OF THE PETITIONER

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INTEREST OF THE AMICUS CURIAE

Right To Life Advocates, Inc., Amicus Curiae herein ("Life Advocates"), is a nonprofit corporation organized in 1974 under the laws of the State of Texas and has a tax exempt status under §501(c)(4) of the Internal Revenue Code. It is a pro-life advocacy organization interested in the preservation of the sanctity of human life from its commencement until natural death.[1]

All parties to this cause have consented to the filing of this Brief. Documents expressing such consent are being submitted for filing herewith.

SUMMARY OF THE ARGUMENT

The Court of Appeals held the Partial-Birth Abortion Ban Act of 2003, 117 U.S. Stat. 1206-1207, Sec. 3 ("The Act"), facially unconstitutional for three reasons, namely, that it lacked an exception for preservation of maternal health, that it posed an undue burden on women seeking previability abortions and that it was impermissibly vague. These holdings lack merit.

A. The first two reasons stemmed from the abortion liberty fashioned by *Roe v. Wade*, 410 U.S. 113 (1973), amplified in part by *Doe v. Bolton*, 410 U.S. 179 (1973), and repudiated in part and reaffirmed in part by *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 883

[1] This Brief was not authored in whole or in part by any counsel for a party in this cause, and no outside person or entity made any monetary contribution toward the preparation or submission of this Brief. See this Court's Rule 37.6.

(1992). The Court of Appeals erred in holding The Act facially unconstitutional for such reasons since *Roe* and *Doe* are void as violative of the Constitution and, hence, have no legal efficacy. Those decisions and their progeny should be overruled as decided wrongly.

1. The unconstitutionality of *Roe* and *Doe* is stark and pervasive. See pp. 10-24 of the AMICUS CURIAE BRIEF OF RIGHT TO LIFE ADVOCATES, INC. filed in *Gonzales v. Carhart,* No. 05-380 (*cert. granted* on February 21, 2006), incorporated herein by this reference.

Roe and *Doe* have produced consequences not intended by this Court, namely, (a) resultant abortion on demand, (b) resultant harmful effect on Children who "survive" abortion and (c) resultant internal legal chaos relative to the legal recognition and rights postures of unborn children.

3. Finally, *Roe's* erroneous refusal to resolve the question of when human life commences by resort to biology – the only relevant discipline in such regard – masked the reality of abortion as a destroyer of human life, made it easier to focus on the situation of the pregnant woman and to fashion an abortion liberty from a Constitution silent on the subject and, together with *Doe's* broad definition of maternal health, led to abortion on demand in this Nation. If the Court could not resolve that question in 1973, it surely can now. Human life commences at fertilization when an ovum is fertilized by a sperm cell. *Harvard Medical School Family Health Guide* (2005), p. 903.

B. If *Roe* and *Doe* are valid decisions, the Court of Appeals erred in holding The Act facially unconstitutional for want of a maternal health exception and because it

constituted an undue burden to a pregnant woman seeking a post first trimester abortion.

1. *Roe's* maternal health exception was not applicable to The Act. In this regard, the *Roe* Court pointed out that "the Texas statutes *that concern us here* are Arts. 1191-1194 and 1196 of the State's Penal Code. These make it a crime to 'procure an abortion,' *as therein defined,* except with respect to 'an abortion procured or attempted by medical advice for the purpose of saving the life of the mother' " (410 U.S. at 117-118 and n. 1). Article 1195 of the former Penal Code of Texas – which made it a crime, during parturition of the mother, to destroy the vitality or life of an Unborn Child "in the state of being born and before actual birth, which child would otherwise have been born alive * * * " – was "not attacked" (*id.* at 118 and n. 1 at 118). In short, *Roe* was concerned with abortion *in utero.* It does not apply to the procedure prohibited by The Act.

In any event, such an exception was obviated by a Congressional Finding that partial-birth abortion "is never medically indicated to preserve the health of the mother" [117 U.S. Stat. 1206, Sec. 2(14)(O)]. The Court of Appeals was required to defer to and accept this and Congress's related consensus Finding if they were reasonably inferred by Congress from substantial evidence before it. *Turner Broadcasting System, Inc. v. FCC,* 520 U.S. 180, 195-196 (1997).

The Court of Appeals, however, said that the "dispositive question" was not the Finding that the prohibited procedures were never necessary, etc., but that, under *Stenberg v. Carhart,* 530 U.S. 914 (2000), "whether there is general agreement in the medical community that there are no circumstances in which the procedure would be necessary

to preserve a woman's health" (435 F.3d at 1175). It challenged Congress's consensus Finding [117 U.S. Stat. 1201, Sec. 2(1)]; and said that "a substantial disagreement exists in the medical community regarding whether those procedures are necessary in certain circumstances for that purpose", and that "[i]n such circumstance", it was "compelled to hold that a health exception is constitutionally required" (435 F.3d at 1174-1175, 1175-1176).

Congress's consensus Finding was derived from three components – moral, ethical and medical – and it was the job of Congress, as fact finder, to sort out differing opinions or presentations on the subject and come to a consensus conclusion which it did. In so doing, it was not required to give operative weight or credibility to claims that partial-birth abortion was necessary for maternal health preservation "in certain circumstances" when either no such "circumstances" were presented or no showing was made that maternal health could have been preserved by an alternative (and safer) means. Hence, that Finding did not undermine Congress's conclusionary Finding, above, which obviated the need for a maternal health exception, and the Court of Appeals erred when it refused to apply the *Turner* standard and defer to and accept each such Finding.

2. The Court of Appeals erred when it determined that The Act constituted an undue burden to a pregnant woman seeking a previability abortion since "properly construed the Act covers non-intact as well as intact D & Es", etc. (435 F.3d at 1179). The Act, however, requires that the affected physician have a certain specific intent, certain knowledge concerning the overt act which kills the Unborn Child and the introduction of lethal force to such Child at a designated anatomical point(s) *outside* the mother's body. The non-intact D & E procedure, which

contemplates dismemberment and death in the uterus through a dilated cervix, does *not* contain these elements or requirements. A physician performing a non-intact D & E would not run afoul of The Act if he were to remove from the mother's body an Unborn Child's skull for piercing, etc. because the introduction of lethal force or means occurred *inside* the woman's body and the Unborn Child would be dead or dying due to dismemberment at the time of such partial removal. In short, The Act requires the coexistence of certain *scienter* and conduct not included in the D & E procedure.

C. Finally, The Act is not impermissibly vague, and the Court of Appeals erred when it held to the contrary. A fair reading of the definition of partial-birth abortion in The Act shows clearly that it does not cover the *non-intact* D & E procedure. Accordingly, it gives fair notice to a person of ordinary intelligence of what is proscribed and is sufficiently explicit to prevent arbitrary or discriminatory law enforcement of it. See *Kolender v. Lawson,* 461 U.S. 352, 357 (1983); *Grayned v. City of Rockford,* 408 U.S. 104, 108-109 (1972).

In this regard, (1) in the D & E procedure the lethal force or means is introduced *into the mother's uterus* through a dilated cervix *whereas* in The Act the lethal force or means is introduced when the Unborn Child has been delivered vaginally to a designated anatomical point(s) *outside the mother's body;* (2) in the D & E procedure the physician's intent is to dismember (and kill) the Unborn Child *in utero whereas* in The Act the physician's intent is to deliver the Unborn Child vaginally to a designated anatomical point(s) outside the mother's body for the purpose of killing such Child at such point(s); and (3) in the D & E procedure the Unborn Child either is killed

in utero or is in the process of dying when pulled outside the mother's body *whereas* in The Act the Unborn Child is alive when partially delivered and killed at a designated anatomical point(s) outside the mother's body by an overt act other than completion of delivery which the physician knows will kill such Child. In short, the *scienter,* conduct and place of killing are altogether different between The Act and the D & E procedure.

ARGUMENT

I.

THE HOLDINGS BY THE COURT OF APPEALS THAT THE ACT WAS FACIALLY UNCONSTITUTIONAL BASED ON REASONS STEMMING FROM THE ABORTION LIBERTY ARE ERRONEOUS SINCE *ROE V. WADE* AND *DOE V. BOLTON* WHICH UNDERLIE SUCH HOLDINGS WERE DECIDED WRONGLY AND SHOULD BE OVERRULED

A. Introduction. The Court of Appeals held that the Act was facially unconstitutional for three reasons, the first two of which are addressed in this Section and in Section II, *infra*. The first reason was that The Act did not include an exception for preservation of maternal health per *Roe v. Wade, supra,* 410 U.S. 113, and *Stenberg v. Carhart, supra,* 530 U.S. 914.

The second reason was that it posed an "undue burden" on a pregnant woman's right to choose a previability abortion because "properly construed The Act covers non-intact as well as intact D&Es" (435 F.3d at 1179). See *Casey, supra,* 505 U.S. at 878, 879. It said that the Act is "sufficiently broad to cause those who perform non-intact D&E procedures to 'fear prosecution, conviction, and imprisonment'

[citing *Stenberg*]", with a resultant "chilling effect on doctors' willingness to perform previability post-first trimester abortions * * * " (435 F.3d at 1179).

Since the Court's holdings involve the application and/or interpretation of (1) *Roe's* health exception, as amplified in *Doe* and applied in *Stenberg,* and as reaffirmed in *Casey,* and (2) *Casey's* reaffirmation of *Roe's* central holding, Life Advocates submits the Court should take the opportunity which this case presents to reconsider the constitutional and other aspects of *Roe* and *Doe* to determine whether they were decided wrongly and, if so, to overrule them and their progeny accordingly. For the reasons and authorities presented herein, Life Advocates submits that *Roe* and *Doe* should be reconsidered and overruled as decided wrongly, and that their progeny, including *Casey* and *Stenberg,* should be overruled in like manner.

B. *Roe* and *Doe* Should Be Overruled. At the threshold, the Court of Appeals was not required to consider whether The Act should include *Roe's* maternal health exception, as amplified by *Doe,* or whether The Act constituted an "undue burden" to women seeking previability abortions, because *Roe* and *Doe* are void as violative of the U.S. Constitution and, hence, have no legal efficacy. They and all decisions of this Court applying those decisions should be overruled as decided wrongly. The reasons in support of this position are described below:

1. Unconstitutionality. The unconstitutionality of *Roe* and *Doe* is stark and pervasive. See pp. 10-24 of the AMICUS CURIAE BRIEF OF RIGHT TO LIFE ADVOCATES, INC. in *Gonzales v. Carhart,* No. 05-380 (*cert. granted* on February 21, 2006), incorporated by reference

herein. This Court, like any other court in this Nation, is capable of violating the Constitution in a case before it and has done so. See *Swift v. Tyson,* 16 Pet. 1, 18-20 (1842), overruled in *Erie R. v. Tompkins,* 304 U.S. 64 (1938); *Plessy v. Ferguson,* 167 U.S. 537 (1896), repudiated in *Brown v. Board of Education of Topeka, Kansas,* 347 U.S. 483 (1954). Thus, in *Erie,* this Court, speaking through Justice Brandeis, stated, in part (pp. 77-78, 78, 79-80):

> * * * If only a question of statutory construction was involved, we should not be prepared to abandon a doctrine [declared in *Swift v. Tyson*] so widely applied throughout nearly a century. But the *unconstitutionality* of the course pursued has now been made clear and compels us to do so.
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> * * *
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> * * * There is no general federal common law. Congress has no power to declare substantive rules of common law applicable to a State whether they be local in nature or "general," be they commercial law or part of the law of torts. *And no clause in the Constitution Purports to confer such a power upon the federal courts.* * * *
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> * * *
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> * * * In disapproving that doctrine we do not hold unconstitutional § 34 of the Federal Judiciary Act of 1789 or any other Act of Congress. We merely declare that *in applying the doctrine this Court and the lower courts have invaded rights which in our opinion are reserved by the Constitution to the several States.* (Emphasis added.) (Footnote omitted.)

2. Unintended Consequences. *Roe* and *Doe* have produced consequences not intended by this Court. Thus:

a. Abortion on Demand. In *Roe,* this Court disagreed with the argument of appellant and some *amici* "that the woman's right is absolute and that she is entitled to terminate her pregnancy at whatever time in whatever way, and for whatever reason she alone chooses" (410 U.S. at 153). "Plainly, the Court today rejects any claim that the Constitution requries abortion on demand" (410 U.S. at 208, Burger, C.J., concurring in *Roe* and *Doe*). In *Doe,* this Court said that "*Roe v. Wade, supra,* sets forth our conclusion that a pregnant woman does not have an absolute constitutional right to an abortion on her demand" (410 U.S. at 189).[2]

Common knowledge shows that just the opposite has occurred and continues to this day, to which this Court is requested to take judicial notice. Millions of Unborn Children have been killed by abortion on demand in this Nation, and millions more will suffer the same fate so long as *Roe* and *Doe* and what they have wrought persists. Even where a State proscribes abortion after viability, the health exception required by *Roe* and amplified in *Doe* is so broad that such a prohibition is more form than substance.

b. Harmful Effect on Children Who "Survive" Abortion. The abortion liberty and its "ethic" have resulted in the deaths of Children who "survive" abortion. These Children, who, with minor exceptions, are U.S. Citizens, die primarily from prematurity, abortional injury or lack of care. See 126 "Am. J. Obstet. Gynecol." (Sept. 11, 1976), pp. 83-89. Sometimes they are murdered outright.

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[2] *Roe's* reach into post-viability abortions was not readily apparent since the Court defined maternal health (for exception purposes to regulation or proscription after viability) very broadly *elsewhere* – in *Doe. Roe* and *Doe* are to be read together (*Roe*, 410 U.S. at 165).

See *Showery v. State,* 690 S.W.2d 689 (Tex. App. – El Paso 1985, pet. ref.), where a Girl brought forth alive after a hysterotomy abortion with estimated weight of 3, 5 and 5-6 pounds was killed after the physician pressed the placenta over her face and immersed her in a bucket of water. This Court in *Roe* and *Doe* did not even consider the plight of such Children, let alone mandate or even counsel for their protection after births in environments hostile to their continued lives.

Moreover, since "unsuccessful" abortions – those resulting in live births – could translate into legal claims against the physicians, etc., "success" is encouraged to the naked detriment of infant U.S. Citizens. See *The Ladies Center of Clearwater Inc. v. Reno,* 341 S.2d 543, 544 (Fl. App., 2d Dist., 1977); *Stills v. Gratton,* 127 Cal. Rptr. 652, 653-656 (Cal. App., 1st Dist., 1976).

c. Internal Legal Chaos. *Roe* has introduced legal chaos into U.S. States and Territories relative to the position of Unborn Children. As shown on pp. 13-15 of Life Advocates' Amicus Curiae Brief, above, incorporated herein by this reference, unborn Children have recognized legal statuses and rights postures – vested and contingent – in civil law, including U.S. statutory law, yet they may be destroyed along with all such rights by exercise of the abortion liberty. This is an affront to logic, not to mention justice, and makes the efficacy of legal rights in such context depend not on their merits but on the desires and actions of others – a stark contradiction to the rule of law. Where interests and rights conflict, it is reasonable that the judiciary should act to harmonize and adjust them, not allow those of one side of the equation to trump those on the other with a tool of total destruction.

3. Deleterious Effect of the Court's Erroneous Refusal To Resolve the Question of When Human Life Begins. The *Roe* Court said that it "need not resolve the difficult question of when life begins. When those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus, the judiciary, *at this point in the development of man's knowledge,* is not in a position to speculate as to the answer", 410 U.S. at 159. (Emphasis added.) This was error since the very issue before the Court involved the question whether the Constitution authorized the destruction of that life by abortion.

The effect of the Court's refusal to resolve that question was impermissibly awkward and harmful to the Court's interpretative approach to the Constitution since it made it easier to focus on the pregnant woman and fashion and present for acceptance a new constitutional right of abortion on demand. After all, there was no determination by the Court that a pregnant woman carried human life within her. This deficiency, coupled with the Court's calling what she carried within her "potential life" or the "potentiality of life," operated to downplay the killing effect by her exercise of the abortion liberty. Had that question been resolved by the only relevant discipline – human biology – it would have been difficult at best to fashion such a liberty from a Constitution silent on the subject and in the face of substantial legal and protective tradition for Unborn Children in this Nation.

Resolution of the question of when human life begins would not have been difficult. It was common knowledge supported by biological facts at that time that human life commenced at conception (fertilization). Unborn Children are live human beings from fertilization forward. See Life

Advocates' Amicus Curiae Brief, *supra*, p. 19, incorporated herein by this reference.

Finally, if the Court could not resolve that question in 1973, it surely can now. See *Harvard Medical School Family Health Guide* (2005) which states, in part, that "[e]ach person begins life as a single cell, after an egg cell from a woman has been fertilized by a sperm cell from a man" (p. 903). See Kenner and Wright, *Comprehensive Neonatal Nursing* (2003), which states, in part, that "[t]he process of human development begins with the fertilization of an ovum (female gamete) by a spermatocyte (male gamete)" (p. 151).

II.

IF *ROE V. WADE* AND *DOE V. BOLTON* ARE VALID DECISIONS, THE HOLDINGS BY THE COURT OF APPEALS THAT THE ACT WAS FACIALLY UNCONSTITUTIONAL BASED ON REASONS STEMMING FROM THE ABORTION LIBERTY ARE ERRONEOUS SINCE (1) *ROE* DOES NOT APPLY TO THE PROCEDURE PROHIBITED BY THE ACT, (2) IF *ROE* DOES APPLY, ITS MATERNAL HEALTH EXCEPTION WAS NOT REQUIRED FOR INCLUSION IN THE ACT AND (3) THE ACT DOES NOT VIOLATE THE UNDUE BURDEN STANDARD OF *CASEY*

A. Background. 1. The Maternal Health Exception. In *Roe*, this Court held that "subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother" (410 U.S. at 164-165). In *Doe*, this

Court agreed with the District Court "that the medical judgment [of the attending physician] may be exercised in light of *all factors – physical, emotional, psychological, familial and the woman's age-relevant to the well being of the patient.* All of these factors may relate to health" (410 U.S. at 192). (Emphasis added.) *Roe* and *Doe* are to be read together (*Roe,* 410 U.S. at 165).

In *Casey, supra,* 505 U.S. 833, this Court, *inter alia,* rejected the "rigid trimester framework of *Roe*"; fashioned an "undue burden" analysis in order to protect the central right "recognized" in *Roe* and to accommodate the State's "profound interest in potential life"; and reaffirmed the central holding of *Roe* and its post-viability abortion holding, above (*id.* at 878, 879). In describing such analysis, the Court said that "[a]n undue burden exists, and therefore a provision of law is invalid, if its purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability" (p. 878).

2. This Court's Decision in *Stenberg v. Carhart.* In *Stenberg v. Carhart, supra,* 530 U.S. 914, this Court held unconstitutional Nebraska's statutory ban on partial birth abortions ("D&X" procedures) because it lacked an exception for preservation of maternal health – an exception which stems from *Roe* and is amplified definitionally in *Doe* – and, because of such deficiency, placed an undue burden on the ability of women to choose abortion. The Court pointed out that the District Court found that "D&X significantly obviates health risks in certain circumstances" (p. 936), and held that "a statute that altogether forbids D&X creates a significant health risk" (p. 938).

3. The Act. Section 3 of The Act amends Title 18 of the United States Code by making it a crime for "[a]ny physician who, in or affecting interstate or foreign commerce, knowingly performs a partial-birth abortion and thereby kills a human fetus * * * ." 117 U.S. Stat. 1206, Sec. 3. This "does not apply to a partial-birth abortion that is necessary to save the life of the mother whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself." *Ibid.* The Act does not include an exception for preservation of maternal health.

The Act defines partial-birth abortion to mean an abortion where the person performing it (*id.* at 1206-1207, Sec. 3)

> (A) *deliberately and intentionally* vaginally delivers a living fetus *until*, in the case of a head-first presentation, the entire fetal head is *outside* the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is *outside* the body of the mother, *for the purpose of performing an overt act* that the person *knows* will kill the partially delivered living fetus; and
>
> (B) performs the overt act, *other than completion of delivery*, that kills the partially delivered living fetus. (Emphasis added.)

4. Certain Relevant Congressional Findings. In Sec. 2 of The Act, "FINDINGS", Congress made a number of findings and declarations, including the following (117 U.S. Stat. 1201, 1204, 1206, Sec. 2):

> (1) *A moral, medical, and ethical consensus exists that the practice of performing a partial-birth abortion * * * is a gruesome and inhumane*

procedure that is never medically necessary and should be prohibited.

* * *

(14) Pursuant to testimony received during extensive legislative hearings during the 104th, 105th, 107th, and 108th Congresses, Congress finds and declares that:

* * *

(C) A prominent medical association has concluded that partial-birth abortion is "not an accepted medical practice", that it has "never been subject to even a minimal amount of the normal medical practice development," that "the relative advantages and disadvantages of the procedure in specific circumstances remain unknown," and that "there is no consensus among obstetricians about its use". The association has further noted that partial-birth abortion is broadly disfavored by both medical experts and the public, is "ethically wrong," and "is never the only appropriate procedure".

* * *

(O) For these reasons, Congress finds that partial-birth abortion *is never medically indicated to preserve the health of the mother; is in fact unrecognized as a valid abortion procedure by the mainstream medical community; poses additional health risks to the mother; blurs the line between abortion and infanticide in the killing of a partially-born child just inches from birth; and confuses the role of the physician in childbirth and should, therefore, be banned.* (Emphasis added.)

B. *Roe* and *Doe* Do Not Apply to the Procedure Prohibited by The Act. The abortion liberty fashioned

by *Roe* and amplified in part in *Doe* does not apply to the process of childbirth, whether occurring naturally or by way of induction. In this regard, the *Roe* Court pointed out that "[t]he Texas statutes *that concern us here* are Arts. 1191-1194 and 1196 of the State's Penal Code. These make it a crime to " 'procure an abortion,' *as therein defined,* except with respect to 'an abortion procured or attempted by medical advice for the purpose of saving the life of the mother.' " (*id.* at 117-118 and n. 1). (Emphasis added.) Article 1191 defined "abortion" to mean "that the *life* of the fetus or embryo *shall be destroyed in the woman's womb* or that a *premature birth thereof be caused.*" *Ibid.* (Emphasis added.)

The Court said that Article 1195 was "not attacked", and quoted it as follows (*id.* at 118 and n. 1 at 118):

> "Art. 1195. Destroying unborn child
>
> "Whoever shall *during parturition of the mother* shall destroy the vitality or life in a child *in the state of being born and before actual birth, which child would otherwise have been born alive,* shall be confined in the penitentiary for life or for not less than five years." (Emphasis added.)

Article 1195 is now Art. 4512.5, *Vernon's Tex. Civ. Stats. Ann.*

Thus, the Court was *not concerned* with the Texas prohibition against destruction of the life of an Unborn Child "in the state of being born and before actual birth" under Article 1195, above. *Nor* is there anything in *Roe* to show any reach of the abortion liberty to a partial-birth procedure like that described in The Act. See Congress' related finding at 117 U.S. Stat. 1205, Sec. 2(14)(H).

Hence, *Roe's* maternal health exception for abortions after viability, as amplified in *Doe,* simply does not apply to The Act – where (1) the physician intends to and does deliver vaginally an Unborn Child to a particular anatomical point(s) outside the mother's body for the purpose of killing such Child at such point(s), and (2) the physician kills such Child by an overt act (other than the completion of delivery) which the physician knows will kill such Child.

In short, *Roe* applies to abortion *in utero* – where the lethal chemicals, drugs and/or surgical instruments are introduced *into* the uterus of a pregnant woman for the purpose or killing or commencing the killing of her Unborn Child then and there. The Act, on the other hand, seeks to prohibit the introduction of a killing force by overt act other than completion of delivery *after* the Child is partially delivered to a specified anatomical point(s) *outside* the mother's body. Since *Roe* does not apply to the partial-birth procedure prohibited by The Act, the Court of Appeals erred in holding The Act facially unconstitutional for want of *Roe's* maternal health exception.

C. *Roe's* Maternal Health Exception Was Not Required for Inclusion in The Act. Finally, if *Roe* and *Doe* are valid decisions, Congressional Findings underlying enactment of The Act *obviated* any need for inclusion therein of a maternal health exception. As shown above, Congress found, in part, (1) that "[a] moral, medical, and ethical consensus exists that the practice of performing a partial-birth abortion * * * is a gruesome and inhumane procedure that is never medically necessary and should be prohibited", and (2) that "partial-birth abortion is never medically indicated to preserve the health of the mother" [117 U.S. Stat. 1201, 1206, Sec. 2(1) and (14)(O)]. So long

as these Findings were inferred reasonably from substantial evidence before Congress they were binding on the Court of Appeals. *Turner Broadcasting System, Inc. v. FCC, supra*, 520 U.S. at 195-196.

The Court of Appeals, however, said that the "dispositive question" was not the Finding that the prohibited procedures were never necessary, etc., but that, under *Stenberg*, "whether there is general agreement in the medical community that there are no circumstances in which the procedure would be necessary to preserve a woman's health" (435 F.3d at 1175). It challenged Congress's consensus Finding [117 U.S. Stat. 1201, Sec. 2(1)]; and said that "a substantial disagreement exists, in the medical community regarding whether those procedures are necessary in certain circumstances for that purpose" and, "[i]n such circumstance" it was "compelled to hold that a health exception is constitutionally required" (435 F.3d at 1174-1175, 1175-1176). This was error.

As shown above, the consensus which Congress found was a "moral, medical, and ethical" one. From a moral and ethical standpoint it is almost axiomatic that such a consensus would exist without more.

From a medical standpoint, the fact that there was disagreement as to the necessity of the procedure in some – unspecified – circumstances for preservation of maternal health does not undermine such consensus Finding. The Finding was derived from three components – moral, ethical and medical – and it was the job of Congress, as fact-finder, to sort out differing opinions or presentations on the subject and come to a consensus conclusion which it did. In so doing, it was *not* required to give operative weight or credibility to claims that partial-birth abortion was necessary for health preservation "in some circumstances"

when either no such "circumstances" were presented *or* no showing was made that maternal health could have been preserved by alternate (and safer) means.[3] Accordingly, the consensus Finding did not subvert or impugn Congress' conclusionary Finding obviating the need for such exception – that "partial-birth abortion is never medically indicated to preserve the health of the mother * * * " [117 U.S. Stat. 1206, Sec. 2(14)(O)] – and the Court of Appeals erred when it refused to defer to and accept each such Finding by application of the *Turner* standard.

The thrust of the approach taken by the Court of Appeals appears to be that such a "consensus" could not exist where there were divergent medical opinions on the issue of need for such health exception. Such an approach not only denigrates Congress' investigative role as a fact-finder herein, including credibility determinations, but extends trump value to opposing advocates with opinions lacking in substantiation or completeness.

D. The Act Does Not Constitute an Undue Burden to a Pregnant Woman Seeking a Previability Abortion. The Court of Appeals also held The Act facially unconstitutional because it presented an "undue burden" to a pregnant woman seeking a previability abortion since "properly construed the Act covers non-intact as well as intact D & Es. As a result, * * * the Act is sufficiently broad to cause those who perform non-intact D & E procedures to 'fear prosecution, conviction, and imprisonment' [citing *Stenberg*]. The resulting chilling effect on doctors'

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[3] Congress found that "[p]artial-birth abortion poses serious risks to the health of a woman undergoing the procedure", and specified a number of such risks [117 U.S. Stat. 1204, Sec. 2(14)(A)].

willingness to perform previability post-first trimester abortions would impose an undue burden on the constitutional rights of women" (435 F.3d at 1179). This holding is without merit.

At the threshold, an examination of the Dilatation and Evacuation abortion procedure ("D & E") is in order. See "Abortion[,] Some Medical Facts" (NRL Educational Trust Fund, Washington, D.C.) (1996), p. 13:

> *Dilatation and Evacuation (D & E)*
>
> Used to abort unborn children as old as 24 weeks, this method is similar to the D&C. The difference is that forceps with sharp metal jaws are used to grasp parts of the developing baby, which are then twisted and torn away. This continues until the child's entire body is removed from the womb. Because the baby's skull has often hardened to bone by this time, the skull must sometimes be compressed or crushed to facilitate removal. If not carefully removed, sharp edges of the bones may cause cervical laceration. Bleeding from the procedure may be profuse. (Footnote omitted.)

As shown above, there are three distinct elements of the offense which distinguishes partial-birth abortion, as defined in The Act, from non-intact D & E abortion. These are: (1) the *specific intent* of the physician to deliver vaginally an Unborn Child to a designated anatomical point(s) *outside* the mother's body *for the purpose of killing such Child at such point(s)*; (2) the *introduction of lethal force or means* to such Child *at such point(s)* by an overt act other than completion of such delivery which the physician *knows* will kill such Child; and (3) the actual

killing of such Child at such point(s). The "non-intact" D & E procedure does *not* contain these elements or features.

What the Court of Appeals failed to appreciate was that The Act requires the affected physician to have a certain specific intent, certain knowledge concerning the overt act which kills the Unborn Child and the introduction of lethal force or means to such Child at a designated anatomical point(s) outside the mother's body where the Child is killed. On the other hand, the non-intact D & E procedure, which contemplates dismemberment and death of such Child in the uterus through a dilated cervix, does not contain these elements or requirements. A physician performing a non-intact D & E would not run afoul of The Act if he were to remove from the mother's body an Unborn Child's skull for piercing, etc. *because* the introduction of lethal force or means would have occurred inside the mother's body and the Unborn Child would be dead or dying due to dismemberment at the time of such partial removal. Hence, the undue burden holding by the Court of Appeals, above, falls with its predicate.

The Court claims that the *scienter* provisions of The Act could not save it from such undue burden since "the actions described in the statute's definition of the prohibited procedure can be performed with the requisite intent in both the intact and the non-intact forms of the D & E procedure" (435 F.3d at 1180). The Court gave an example of how this might occur (*id.*).

The Court's position, together with its example, is speculative rather than realistic. Thus, a physician intending to perform a D & E abortion intends to and does introduce an instrument(s) through the woman's dilated cervix and commences to kill the Unborn Child by

dismemberment; he does not intend to deliver vaginally such Child partially outside the mother's body for the purpose of killing him or her there. Hence, The Act by intent and conduct does not reach non-intact D & C abortions.

As for the Court's example, The Act is neither implicated nor violated where the physician "performing a non-intact D & E" where the Unborn Child is in the breech position decides to "minimize the number of disarticulated fetal parts removed from the woman's body" and removes such Child vaginally to the specified point(s) in The Act, etc. *because* (1) the physician's intent was to do a D & E (dismemberment) procedure *in utero*, (2) such procedure was commenced and involved the introduction of lethal force or means *in utero*, (3) such procedure produces either a dead or dying Unborn Child prior to his or her partial removal from the mother's body and (4) the physician's intent in such partial removal was for the purpose of minimizing "the number of disarticulated fetal parts" and *not* for the purpose of killing the Unborn Child at such point(s) by an overt act other than completion of delivery which he or she knew would kill such Child. In other words, the *scienter* and conduct elements of the proscribed conduct show clearly that The Act could not and would not cover what the Court claims it does.

III.

THE HOLDING BY THE COURT OF APPEALS THAT THE ACT WAS FACIALLY UNCONSTITUTIONAL BECAUSE IT WAS IMPERMISSIBLY VAGUE IS ERRONEOUS

Finally, the Court of Appeals erred reversibly when it held The Act facially unconstitutional due to impermissible vagueness. As shown above, however, the definition of

the prohibited conduct is sufficiently precise and clear (1) to permit a person of ordinary intelligence to understand what is proscribed and (2) to prevent arbitrary or discriminatory law enforcement of The Act. See *Kolender v. Lawson, supra,* 461 U.S. at 357; *Grayned v. City of Rockford, supra,* 408 U.S. at 108-109.

The essence of the Court's position on vagueness is that The Act "fails to define clearly the medical procedures it prohibits, depriving doctors of fair notice and encouraging arbitrary enforcement", that its "scienter requirements do not cure the statute's vagueness" (435 F.3d at 1181). It said also that it might conclude that "the statute covers both forms of D & E, the language of the statute, taken as a whole, is not sufficiently clear what it permits and prohibits to guide the conduct of those affected by its terms, specifically medical practitioners" (*id.* at 1182-1183). This holding is without merit.

A fair reading of definition of partial-birth abortion in The Act shows clearly and precisely what is proscribed. It shows clearly that it does not cover non-intact D & E procedures.

In this regard, (1) in the D & E procedure the lethal force or means is introduced *into the mother's uterus* through a dilated cervix *whereas* in The Act the lethal force or means is introduced when the Unborn Child has been delivered vaginally to a designated anatomical point(s) *outside the mother's body*; (2) in the D & E procedure the physician's intent is to dismember (and kill) the Unborn Child *in utero whereas* in The Act the physician's intent is to deliver the Unborn Child vaginally to a designated anatomical point(s) outside the mother's body for the purpose of killing such Child at such point(s); and

(3) in the D & E procedure the Unborn Child either is killed *in utero* or is in the process of dying when pulled outside the mother's body *whereas* in The Act the Unborn Child is killed at a designated anatomical point(s) outside the mother's body by an overt act other than completion of delivery which the physician knows will kill such Child. In short, the *scienter,* conduct and place of killing are altogether different between The Act and the D & E procedure.

Such clarity and precision extend to a person of ordinary intelligence – and certainly to a medical practitioner – sufficient information as to what constitutes proscribed conduct and, by the same token, operate to prevent arbitrary or discriminatory law enforcement. See *Kolender v. Lawson, supra,* 461 U.S. at 357; *Grayned v. City of Rockford, supra,* 408 U.S. at 108-109. In addition, the *scienter* requirements operate to narrow the reach of The Act so that practitioners of D & E abortions need not fear that they are violating it.

CONCLUSION

For the reasons and authorities set forth above, Life Advocates submits respectfully that the Court should (1) reverse the Judgment of the Court of Appeals and render judgment overruling *Roe v. Wade* and *Doe v. Bolton,* and, in the process, hold that an Unborn Child is a person under the 14th Amendment's Due Process Clause; or (2) if the relief in "(1)" is not granted, reverse the Judgment of the Court of Appeals and render judgment holding The Act constitutional; or (3) if the relief in "(2)" is not granted, reverse such Judgment and remand the cause to the Court

of Appeals with instructions that it apply the review standard described in *Turner*, above.

Respectfully submitted,

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Supreme Court of the United States

ALBERTO R. GONZALES, ATTORNEY GENERAL,
Petitioner.
v.

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC., et al.
Respondents.

On Writ of Certiorari to the
United States Court of Appeals for the Ninth Circuit

BRIEF FOR AMICI CURIAE JILL STANEK AND THE ASSOCIATION OF PRO-LIFE PHYSICIANS IN SUPPORT OF PETITIONER

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QUESTION PRESENTED

The Partial-Birth Abortion Ban Act of 2003 (the Act), Pub. L. No. 108-105, 117 Stat. 1201 (to be codified at 18 U.S.C. 1531), prohibits a physician from knowingly performing a "partial-birth abortion" (as defined in the statute) in or affecting interstate commerce. Section 3, 117 Stat. 1206-1207. The Act contains an exception for cases in which the abortion is necessary to preserve the life of the mother, but no corresponding exception for the health of the mother. Congress, however, made extensive factual findings, including a finding that "partial-birth abortion is never medically indicated to preserve the health of the mother." Section 2 (14)(O), 117 Stat. 1206. The question presented is:

Whether, notwithstanding Congress's determination that a health exception was unnecessary to preserve the health of the mother, the Partial-Birth Abortion Ban Act of 2003 is invalid because it lacks a health exception or is otherwise unconstitutional on its face.

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INTEREST OF AMICI CURIAE[1]

Jill Stanek is a registered nurse who witnessed firsthand aborted babies being born alive and then left to die, when she worked in the Labor & Delivery Department at Christ Hospital in Oak Lawn, Illinois. Mrs. Stanek brought the issue of "live-birth" abortions into the public eye in 1999. Her disclosure gained the attention of Congress, which subsequently adopted the Born Alive Infants Protection Act ("Born Alive Act") in 2002. Mrs. Stanek testified before Congress in 2000 and 2001 during committee hearings on the Born Alive Act and has since become a recognized leader in the fight to protect the rights of unborn and partially born children. Mrs. Stanek's testimony was also read into the record by Sen. Rick Santorum (R-Pa) during Senate floor debates for the Partial-Birth Abortion Ban Act that is the subject of this action. Mrs. Stanek was invited by President George W. Bush to attend the August 2002 signing of the Born Alive Act and the November 2003 signing of the Partial-Birth Abortion Ban Act.

The Association of Pro-Life Physicians ("The Association") is a national organization of physicians who are convinced that abortion kills an innocent human being and are committed to not performing or referring patients for an abortion. The Association seeks to employ its medical expertise and influence in the members' respective

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[1] Amici file this brief with the consent of all parties. The letters granting consent of the parties are attached hereto with the filing of this brief. Counsel for a party did not author this brief in whole or in part. No person or entity, other than *Amici Curiae* or their counsel, made a monetary contribution to the preparation and submission of this brief.

communities to educate the public on the humanity and viability of the preborn child, and to encourage alternative responses to crisis pregnancies.

Mrs. Stanek and the Association are acutely aware of the need to recognize and protect the inalienable right to life for unborn and partially born children. As medical professionals, Mrs. Stanek and the Association are also acutely aware of the threat that "partial-birth abortion" poses to the integrity of the medical profession. The Partial-Birth Abortion Ban Act is critical to securing and preserving those rights. Mrs. Stanek and the Association want to ensure that this Court has the information necessary to examine the Partial-Birth Abortion Ban Act from the perspective of the state's interest in protecting the integrity of the medical profession and its longstanding role as the protector and preserver of human life.

SUMMARY OF ARGUMENT

When a physician intentionally replaces his lab coat with an executioner's robe in the course of delivering a child, then he should be subject to criminal sanctions. That is the message that Congress communicated when it enacted the Partial-Birth Abortion Ban Act of 2003 (the "Act"). Congress rightly determined that a procedure in which a child is delivered to within inches of birth for the sole purpose of being brutally killed is fundamentally incompatible with the physician's role as healer and must be banned. As Justice Kennedy observed:

> A State may take measures to ensure the medical profession and its members are viewed as healers, sustained by a compassionate and rigorous ethic and cognizant of the dignity and value of human life, even

life which cannot survive without the assistance of others.

Stenberg v. Carhart, 530 U.S. 914, 961 (2000) (Kennedy, J. dissenting). Congress has done that by banning a procedure that "undermines the public's perception of the appropriate role of a physician during the delivery process." Partial-Birth Abortion Ban Act of 2003, Pub. L. No. 108-105, 117 Stat. 1201, 1205.

Congress has taken sides in a medical debate "fraught with medical and scientific uncertainties" and appropriately sided with the "common belief" that the physician is obligated to preserve and protect life, not seek to destroy it. *See Marshall v. United States*, 414 U.S. 417, 427 (1974). Congress was faced with a conflict between statements from practitioners who perform "partial-birth abortions"[2] that the operation is a legitimate medical procedure and statements from other physicians that the procedure is unproven, unsafe and never medically necessary. Congress legitimately sided with the latter group, recognizing that banning the procedure comported with the physician's oath to preserve and protect life and preventing subversion of the physician's role as healer.

In defining "partial-birth abortion," Congress included a scienter element that further emphasizes the distinction between the banned procedure and conventional medical

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[2] Throughout this Brief, Amici will use the term "partial-birth abortion" to refer to the procedure defined in the statute. Partial-Birth Abortion Ban Act of 2003, Pub.L. No. 108-105, 117 Stat. 1201, 1204-1206 (2003). Since that procedure is arguably not an abortion, as discussed below, Amici will set off the phrase with quotation marks.

practice. That precise definition further demonstrates that the prohibited procedure is designed to destroy rather than preserve life and is therefore antithetical to the physician's role as protector and preserver of life. As such, it has been rightfully banned as impermissibly hostile to the foundational tenet of society – respect for human life.

This Court has repeatedly recognized that the State has legitimate and important interests in safeguarding health, maintaining medical standards and protecting potential life in the context of abortion regulation. *Roe v. Wade*, 410 U.S. 113,154 (1973); *Planned Parenthood of Southeastern Pennsylvania v. Casey,* 505 U.S. 833, 871 (1992). Those interests are even more acute in the case of the procedure that is the subject of the Act since the child is only inches from being fully born and, therefore, has an "autonomy which separates it from the right of the woman to choose treatments for her own body." 117 Stat. at 1205. That autonomy means that the Act is not a matter of regulating a "woman's right to choose," but of protecting and defending the integrity of the medical profession in its role as the protector and preserver of life.

ARGUMENT

I

CONGRESS HAS APPROPRIATELY EXERCISED ITS LEGITIMATE STATE INTEREST IN PROTECTING THE INTEGRITY OF THE MEDICAL PROFESSION BY PROHIBITING THE PROCEDURE KNOWN AS "PARTIAL BIRTH ABORTION."

The procedure banned by Congress is not "an abortion procedure that is embraced by the medical community," but "a disfavored procedure that is not only unnecessary to

preserve the health of the mother, but in fact poses serious risks to the long-term health of women and, in some circumstances, their lives." Pub.L. No. 108-105, 117 Stat. 1201 (2003). "A partial-birth abortion is never necessary to preserve the health of a woman, poses significant health risks to a woman upon whom the procedure is performed and is outside the standard of medical care." 117 Stat. at 1202. "Partial-birth abortion also confuses the medical, legal and ethical duties of physicians to preserve and promote life, as the physician acts directly against the physical life of a child, whom he or she had just delivered, all but the head, out of the womb in order to end that life." *Id.* at 1205.

> Partial-birth abortion thus appropriates the terminology and techniques used by obstetricians in the delivery of living children – obstetricians who preserve and protect the life of the mother and the child – and instead uses those techniques to end the life of the partially-born child. Thus, by aborting a child in the manner that purposefully seeks to kill the child after he or she has begun the process of birth, partial-birth abortion undermines the public's perception of the appropriate role of a physician during the delivery process, and perverts a process during which life is brought into the world, in order to destroy a partially-born child.

Id. For these reasons, *inter alia*, "Congress finds that partial-birth abortion . . . is in fact unrecognized as a valid abortion procedure by the mainstream medical community; . . .and confuses the role of the physician in childbirth and should, therefore, be banned." *Id.* at 1206.

Consequently, when it enacted the "Partial Birth Abortion

Ban Act of 2003," Congress was acting pursuant to its "interest in forbidding medical procedures which, in the State's reasonable determination, might cause the medical profession or society as a whole to become insensitive, even disdainful, to life, including life in the human fetus." *Stenberg v. Carhart*, 530 U.S. 914, 961 (2000)(Kennedy, J. dissenting). "A State may take measures to ensure the medical profession and its members are viewed as healers, sustained by a compassionate and rigorous ethic and cognizant of the dignity and value of human life, even life which cannot survive without the assistance of others." *Id.* at 962. As Justice Kennedy stated and Congress subsequently confirmed, "[s]ubstantial medical authority shows that D&X [the dilatation and extraction procedure banned by Congress] perverts the natural birth process to a greater degree than D&E" [dilatation and evacuation] in that it commandeers the live birth process for the purpose of killing the child. *Id* at 962-963; *See* 117 Stat. at 1205. Justice Kennedy found in *Stenberg* that "Nebraska could conclude the ["partial-birth abortion"] procedure presents a greater risk of disrespect for life and a consequent greater risk to the profession and society, which depend for their sustenance upon reciprocal recognition of dignity and respect. The Court is without authority to second-guess this conclusion." *Stenberg*, 530 U.S. at 963. The same must be said for Congress in this case. Congress correctly concluded that the "partial-birth abortion" procedure banned in the Act posed a greater risk for disrespect for life and a greater risk to the integrity of the medical profession than do other procedures.

Congress found support for its conclusion, as did Justice Kennedy, from the American Medical Association, which stated that "'partial-birth abortion' or intact D&X is ethically wrong." AMA Board of Trustees' Fact Sheet on HR 1122

(June 1997), in App. To Brief of Association of American Physicians and Surgeons et al. as Amici Curiae in *Stenberg v. Carhart* 1, 2000 WL 228448. ("AMA Fact Sheet").[3] "The procedure is ethically different from other destructive abortion techniques because the fetus, normally twenty weeks or longer in gestation, is killed outside of the womb. The 'partial birth' gives the fetus an autonomy which separates it from the right of the woman to choose treatments for her own body." AMA Fact Sheet at 1. "In the Board's view Intact D&X is not an accepted 'medical practice.'" *Id.* at 2. "There is no consensus among obstetricians about its use, and the Board's expert scientific report recommends against its use." *Id.* "It has never been subject to even a minimal amount of the normal medical practice development. It is not in the medical text books." *Id.*

In testimony before a joint hearing of the House and Senate judiciary committees, obstetrician Dr. Curtis Cook further explained how the procedure banned by the Act falls far outside the boundaries of legitimate medical procedures.

> There is no record of these procedures in any medical text, journals, or on-line medical service. There is no known quality assurance, credentialing, or other standard assessment usually associated with newly-described surgical techniques. Neither the CDC nor the Alan Guttmacher Institute have any data on partial birth abortion, and certainly no basis upon which to state the claim that it is a safer or even a

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[3] The AMA has opposed the Act because of the association's opposition to criminal sanctions against physicians, but it continues to oppose the procedure banned by the Act. H.R. REP. 108-58 at 15 (2003).

preferred procedure.[4]

"The only possible 'advantage' of partial birth abortion, if you can call it that, is that it guarantees a dead baby at time of delivery."[5] "I believe the unnecessary, unstudied, and potentially dangerous procedure of partial birth abortion is unworthy of continuance in modern obstetrics. It neither protects the life, the health or the future fertility of women, and certainly does not benefit the baby."[6]

As fellow obstetrician Dr. Nancy Romer stated, "When we concentrate on the medical facts, one can find no justification for the continued use of the procedure."[7]

> When a mother experiences medical complications during the second trimester of her pregnancy, what is required to save her life and protect her health *is not the death of her baby, but separation of the baby from the mother*. At stages of early viability, there is no danger in delivering a live baby by appropriate means and allowing neonatal care of the infant. Fetal survival at less than 24 weeks gestation has been reported to be

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[4] Curtis R. Cook, *Testimony of Dr. Curtis R. Cook Before the U.S. Senate Judiciary Committee and the Constitution Subcommittee of the U.S. House Judiciary Committee March 11, 1997*, 14 ISSUES L. & MED. 65, 68 (1998).

[5] *Id.* (emphasis added).

[6] *Id.* at 68-69.

[7] Nancy G. Romer, *The Medical Facts of Partial Birth Abortion*, 3 NEXUS 57, 62 (Fall 1998).

> about 30 percent and overall infant survival between 24 and 26 weeks gestation is reported to be between 50 and 75 percent. Clearly it is more appropriate to deliver the baby and provide neonatal support. In these cases, partial-birth abortion has no advantage over traditional methods of delivery. It is not shorter, and since the mother's health concerns require hospitalization, an outpatient procedure is not safer but riskier.[8]

Even when a woman is carrying a handicapped or deformed baby, "partial-birth abortion" is not medically necessary or preferable for the mother.[9] "The medical fact is that a handicapped fetus, even one with anomalies incompatible with life after birth, is not a threat to a woman's life or health" or "reproductive future."[10] "Partial-birth abortion does have one advantage when the fetus is handicapped: if the handicap is not life threatening to the fetus and there is expectation that the fetus will survive childbirth, partial-birth abortion assures that the fetus will be born dead."[11]

Stripped of the political rhetoric and viewed through the lens of medicine, "partial-birth abortion," therefore, is not merely one choice among many for "terminating a pregnancy," but is a procedure aimed at terminating the life of a partially-born child whom modern medicine has established

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[8] *Id.* at 60. (emphasis added).

[9] *See id.*

[10] *Id.*

[11] *Id.*

is "the second patient, a patient who usually faces much greater risks of serious morbidity and mortality than does the mother."[12] "The unborn child today is treated as a separate patient in his or her own right, not only during childbirth and delivery, but from the earliest ages of gestation."[13] "Just because in one culture some adult human beings are not treated equally or not even given legal rights, does not mean they are not human beings. Science is oblivious to such concepts."[14] It is an indisputable biological fact that "the post implantation human embryo is a distinct human being," and "this biological fact should not be confused with moral or philosophical considerations."[15] That is particularly true when the child is no longer in utero, but is all but a few inches away from being born. The physician's ethical obligation of

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[12] Brief of the American Association of Prolife Obstetricians and Gynecologists(AAPLOG) et. al. as Amici Curiae in Support of Appellants, *Webster v. Reproductive Health Servs.*, 492 U.S. 490 (1989), 1989 WL 1127638 at *5-6, *citing* Pritchard, MacDonald, & Gant, WILLIAMS OBSTETRICS 267 (17th ed. 1985).

[13] THE SOUTH DAKOTA TASK FORCE TO STUDY ABORTION, REPORT SUBMITTED TO THE GOVERNOR AND LEGISLATURE OF SOUTH DAKOTA 26(2005), available at http://www.dakotavoice.com/Docs/South%20Dakota%20Abortion%20Task%20Force%20Report.pdf.

[14] *Id.* at 29, citing Declaration of Dr. Ola Didrik Saugstad.

[15] *Id.* at 30.

"preserving life when there is hope of doing so,"[16] means that when undertaking the delivery of a child, the physician must seek to deliver the baby alive, not, as is the case in "partial-birth abortion," to "perform an overt act that he [the physician] knows will kill" the child.[17]

Similarly, the physician's promise to "practice [his] art in uprightness and honor," uttered as part of the Hippocratic Oath, "cannot include partially delivering a child, only to tear its skull open and kill the child before the delivery is completed."[18] "Can a doctor perform this procedure and coterminously fulfill his duty to uphold medical dignity? He cannot!"[19]

As is true with other aspects of medical practice, including organ donation, prescriptions for narcotics, and other procedures, "[d]octors and patients should not be allowed complete unrestricted autonomy" with regard to "partial-birth abortion."[20] "Clearly the state has a duty and an

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[16] William G. Plested, III, MD, *Physician Participation in Lethal Injection Violates Medical Ethics* (American Medical Association) July 17, 2006, available at http://www.ama-assn.org/ama/pub/category/16556.html.

[17] 117 Stat. At 1201.

[18] Stephanie D. Schmutz, *Infanticide or Civil Rights for Women: Did the Supreme Court Go Too Far in Stenberg v. Carhart?*, 39 HOUS. L. REV. 529, 559 (2002).

[19] *Id.* at 560.

[20] Romer, *The Medical Facts of Partial-Birth Abortion*, at 62.

obligation to provide regulation of medical care."[21]

As this Court has established, that duty and obligation is particularly important in the context of medical procedures dealing with the beginning and end of life. In rejecting arguments that a woman's right to choose abortion is absolute, the *Roe* majority said that "a State may properly assert important interests in safeguarding health, *in maintaining medical standards*, and in protecting potential life." *Roe v. Wade*, 410 U.S. 113,154 (1973) (emphasis added). In reaffirming the "central holding" of *Roe*, the majority in *Casey* again emphasized the state's substantial interests in the regulation of abortion. *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 871-873 (1992). "The very notion that the State has a substantial interest in potential life leads to the conclusion that not all regulations must be deemed unwarranted." *Id.* at 876. Abortion has consequences beyond the woman and the unborn child, but is "fraught with consequences for ... the persons who perform and assist in the procedure [and for] society which must confront the knowledge that the procedures exist, procedures some deem nothing short of an act of violence against innocent human life." *Id.* at 852. The state's interests in regulating abortion and procedures such as "partial-birth abortion" must also extend beyond the women and the unborn child. *Stenberg v. Carhart*, 530 U.S. 914, 962 (2000)(Kennedy, J. dissenting). "A state may take measures to ensure the medical profession and its members are viewed as healers, sustained by a compassionate and rigorous ethic and cognizant of the dignity and value of human life, even life which cannot survive without the assistance of others." *Id.*, *citing Washington v. Glucksberg*, 521 U.S. 702, 730-734

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[21] *Id.*

(1997).

In *Glucksberg* and its companion case, *Vacco v. Quill*, 521 U.S. 793 (1997), the Court upheld state laws against physician-assisted suicide. Just as the Act at issue in this case prohibits physicians from terminating the life of vulnerable partially born children, the acts upheld in *Glucksberg* and *Vacco* prohibited physicians from terminating the life of vulnerable terminally ill patients. In *Glucksberg*, the Court emphasized that "[t]he State also has an interest in protecting the integrity and ethics of the medical profession." 521 U.S. at 731. The *Glucksberg* court rejected the lower court's conclusion that the integrity of the medical profession would not be threatened in any way by physician-assisted suicide. *Id.* As is true with the "partial-birth abortion" procedure in this case, the American Medical Association had concluded that physician-assisted suicide is "fundamentally incompatible with the physician's role as healer," and physicians had testified that it could undermine the trust that is essential to the doctor-patient relationship by blurring the time-honored line between healing and harming. *Id.* Those conclusions substantiated the state's legitimate and valuable interest in promoting and protecting the integrity of the medical profession. *Id.* at 735. In *Vacco*, the Court affirmed that New York's essentially identical reasons for prohibiting physician-assisted suicide – including prohibiting intentional killing, preserving life, and maintaining physicians' role as their patients' healers – were "valid and important public interests [that] easily satisfy the constitutional requirement that a legislative classification bear a rational relation to some legitimate end." 521 U.S. at 808-809. Likewise, Congress's reasons for prohibiting "partial-birth abortion" – to promote maternal health, draw a bright line distinguishing abortion and infanticide, preserve the integrity of the medical profession

and promote respect for human life – are valid and important interests that justify the regulation.

The Partial Birth Abortion Ban Act of 2003 is not, as the trial and appellate courts held, a regulation that imposes an undue burden on a woman's right to obtain an abortion. Instead, it is a necessary and appropriate exercise of Congress's power to preserve and protect the inalienable right to life for all people – born and unborn, preserve the integrity of the medical profession and ensure that the most vulnerable and defenseless citizens are protected from exploitation and extermination. The procedure prohibited by the Act is not an accepted medical procedure, is disfavored by medical experts and the public, is recognized by the medical community as ethically wrong, is destructive of the public's trust in the medical profession and is a perversion of the process that is meant to usher in, not terminate, life. Congress has acted in accordance with this Court's precedents, as well as longstanding medical, legal and ethical tenets, to prohibit physicians from deliberately killing patients just seconds before birth.

II

CONGRESS'S SCIENTER REQUIREMENT IN THE PBA BAN ACT DISTINGUISHES THE PROCEDURE FROM A LEGITIMATE MEDICAL PROCEDURE AND DEMONSTRATES THAT IT IS IN REALITY A PROCEDURE AIMED AT TERMINATING LIFE, WHICH IS ANTITHETICAL TO THE PHYSICIAN'S ROLE AS HEALER.

Congress thoughtfully and carefully drafted the definition of "partial-birth abortion" to include a scienter element – premeditated intent to deliver and kill a partially born child –

that clearly sets it apart from abortions that are protected by this Court's rulings in *Roe* and its progeny. Congress explicitly addressed the concerns this Court raised in *Stenberg v. Carhart*, 530 U.S. 914 (2000) about the imprecision of Nebraska's definition of "partial-birth abortion:"

> The Court's definitional objections have been remedied in H.R. 760 by drafting a more precise definition of the prohibited procedure. Previous versions of the bill defined a partial-birth abortion as "an abortion in which the person performing the abortion partially-vaginally delivers a living fetus before killing the fetus and completing delivery. "The language the Court objected to in *Stenberg* was virtually identical. Under the current version of the ban, "partial-birth abortion" is defined as "an abortion in which – (A) the person performing the abortion deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother *for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus;* and (B) performs the overt act, other than completion of delivery, that kills the partially delivered living fetus.[22]
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> This term is sufficiently precise to address the *Stenberg* Court's concern that the definition of the

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[22] H.R. REP. 108-58 at 6 (2003) (emphasis added).

> prohibited procedure clearly track the medical differences between a partial-birth abortion and other abortions procedures in which the act leading to death occurs in the uterus.[23]

While under *Roe* and *Casey* "a pregnancy may be terminated, partial-birth abortion should not implicate this right because the pregnancy ended once the birth process began and the right to terminate one's pregnancy by aborting one's unborn child does not include an independent right to assure the death of that child regardless of its location to its mother."[24] "This, too, has not gone unnoticed by the American Medical Association, which has recognized that partial-birth abortions are 'ethically different from other destructive abortion techniques because the fetus, normally twenty weeks or longer in gestation, is killed outside of the womb.'"[25] "Thus, by aborting a child in a manner that purposefully seeks to kill a child after he or she has begun the process of birth, partial-birth abortion undermines the public's perception of the appropriate role of a physician during the delivery process and perverts a process during which life is brought into the world in order to destroy a near-breathing child."[26]

Prosecution under the Act, therefore, requires a specific intent to initiate the delivery of a child for the purpose of killing the child when all but his head is outside of the

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[23] *Id.* at 19.

[24] *Id.* at 21-22.

[25] *Id.* at 22.

[26] *Id.*

mother's body. This specific intent to kill a living child approaching birth places the "partial-birth abortion" procedure in the same category as physician-assisted suicide, which requires a specific intent to kill a patient approaching death. In both cases, the physician is acting with the intent to terminate an existing life, not to preserve life or relieve pain. As this Court has established, that distinction is critical in determining whether a statute regulating certain conduct by physicians is constitutional.

In *Vacco v. Quill*, 521 U.S. 793 (1997), this Court discussed the importance of intent and causation in determining whether a prohibition on assisted suicide violates equal protection. If the intent of the physician is to kill the patient, then that violates his role as healer and is properly prohibited, but if the intent is to alleviate pain which then results in the hastening of death, that does not fall within the prohibition. *Id.* at 801-802.

> First, when a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication. Furthermore, a physician who withdraws, or honors a patient's refusal to begin, life-sustaining medical treatment purposefully intends, or may so intend, only to respect his patient's wishes and "to cease doing useless and futile or degrading things to the patient when [the patient] no longer stands to benefit from them." Assisted Suicide in the United States, Hearing before the Subcommittee on the Constitution of the House Committee on the Judiciary, 104th Cong., 2d Sess., 368 (1996) (testimony of Dr. Leon R. Kass). The same is true

> when a doctor provides aggressive palliative care; in some cases, painkilling drugs may hasten a patient's death, but the physician's purpose and intent is, or may be, only to ease his patient's pain. A doctor who assists a suicide, however, "must, necessarily and indubitably, intend primarily that the patient be made dead." *Id.*, at 367. Similarly, a patient who commits suicide with a doctor's aid necessarily has the specific intent to end his or her own life, while a patient who refuses or discontinues treatment might not. Put differently, the law distinguishes actions taken "because of" a given end from actions taken "in spite of" their unintended but foreseen consequences.

Id. at 801-803.

Congress drafted the definition of "partial-birth abortion" with this distinction in mind. The conduct prohibited under the Act is undertaking the delivery of a live unborn child for the purpose of killing the child.[27] In other words, the physician is initiating labor and delivery because it will enable him to perform an "overt act" that he knows will kill the child. [28]As Drs. Cook and Romer explained, the purpose behind the "partial-birth abortion" procedure is not to terminate a pregnancy – i.e., remove the unborn child from the mother's womb – but to kill the child.[29] "Thus, the physician acts directly against the physical life of a child,

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[27] *See* H.R. REP. 108-58 at 22.

[28] *See id.*

[29] Cook, 14 ISSUES L. & MED. at 68; Romer, *The Medical Facts of Partial-Birth Abortion*, at 60.

whom he or she had just delivered all but the head out of the womb, *in order to end that life.*"[30] A physician engaging in "partial-birth abortion," as defined by the Act, is perverting the labor and delivery process, meant to bring life into the world, by using it to end life in the same manner that a physician engaging in assisted suicide is perverting palliative care, meant to improve life, in order to end it. Consequently, just as this Court found in the context of laws prohibiting assisted suicide, this law prohibiting "partial-birth abortion" is an appropriate exercise of Congress's power to regulate the medical profession.

As Justice Stevens has observed:

> There is truth in John Donne's observation that "No man is an island." The State has an interest in preserving and fostering the benefits that every human being may provide to the community – a community that thrives on the exchange of ideas, expressions of affection, shared memories, and humorous incidents, as well as on the material contributions that its members create and support. The value to others of a person's life is far too precious to allow the individual to claim a constitutional entitlement to complete autonomy in making a decision to end that life. Thus, I fully agree with the Court that the "liberty" protected by the Due Process Clause does not include a categorical "right to commit suicide" which itself includes a right to assistance in doing so.

Washington v. Glucksberg, 521 U.S. 702, 740-741 (1997) (Stevens, J. concurring). "In most cases, the individual's

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[30] H.R. REP. 108-58 at 22. (Emphasis added).

constitutionally protected interest in his or her own physical autonomy, including the right to refuse unwanted medical treatment, will give way to the State's interest in preserving human life." *Id.* at 742. Similarly, as Congress found, any right to physical autonomy that might exist in choosing to terminate a pregnancy will give way to the State's interest in preserving human life when the pregnancy has been terminated by delivery of a child with the exception of a few inches.[31] The "liberty interest" asserted in *Roe* and *Casey* "does not include an independent right to assure the death of [a] child regardless of its location to its mother," and Congress "has a heightened interest in protecting the life of the partially-born child."[32] Congress has asserted that interest by enacting a carefully drafted statute that clearly defines the prohibited act.

III

CONGRESS'S PASSAGE OF THE PBA BAN ACT REPRESENTS A LEGITIMATE EXERCISE OF ITS POWER TO RESOLVE MATTERS UPON WHICH PHYSICIANS DISAGREE IN FAVOR OF THE PRESERVATION OF LIFE.

As the evidence before Congress and the lower courts aptly demonstrates, there is some disagreement within the medical community about whether "partial-birth abortion" is an accepted, safe and ethical medical procedure.[33] In such

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[31] *See* H.R. REP. 108-58 at 22.

[32] *Id.*

[33] *See id.* (describing the conflicting medical evidence).

cases, Congress and state legislatures are permitted to "take sides" in the debate and are to be given wide latitude with regard to their final decision. *See Stenberg v. Carhart*, 530 U.S. 914, 970 (2000) (Kennedy, J dissenting). As Justice Kennedy observed, there is "substantial authority allowing the State to take sides in a medical debate, even when fundamental liberty interests are at stake and even when leading members of the profession disagree with the conclusions drawn by the legislature." *Id.*

That substantial authority dates back to at least 1905, when this Court upheld Massachusetts' decision to require that all citizens be vaccinated against smallpox despite testimony from physicians who questioned the effectiveness of the vaccine. *Jacobson v. Massachusetts,* 197 U.S. 11, 30 (1905).

> Looking at the propositions embodied in the defendant's rejected offers of proof, it is clear that they are more formidable by their number than by their inherent value. Those offers in the main seem to have had no purpose except to state the general theory of those of the medical profession who attach little or no value to vaccination as a means of preventing the spread of smallpox, or who think that vaccination causes other diseases of the body. What everybody knows the court must know, and therefore the state court judicially knew, as this court knows, that an opposite theory accords with the common belief, and is maintained by high medical authority. We must assume that, when the statute in question was passed, the legislature of Massachusetts was not unaware of these opposing theories, and was compelled, of necessity, to choose between them. It was not

> compelled to commit a matter involving the public health and safety to the final decision of a court or jury.

Id. Similarly, Congress was aware of the opposing theories regarding the safety and legitimacy of the "partial-birth abortion" procedure, having conducted extensive hearings during the 104th, 105th and 107th legislative sessions.[34] Congress was compelled to choose between the opposing theories, and chose the theory that comported with the "common belief" of the medical community and the American people – that a procedure which perverts the birth process in order to effectuate the brutal killing of a partially born child is antithetical to the role of a physician as healer.

"When Congress undertakes to act in areas fraught with medical and scientific uncertainties, legislative options must be especially broad and courts should be cautious not to rewrite legislation, even assuming, arguendo, that judges with more direct exposure to the problem might make wiser choices." *Marshall v. United States*, 414 U.S. 417,427(1974). "[D]isagreements among medical professionals don't tie the state's hands in setting the bounds of law." *Kansas v. Hendricks*, 521 U.S. 346, 360 n3 (1997).

While Congress had statements from those who perform "partial-birth abortions" that the procedure is safe and appropriate for certain medical conditions,[35] it also had statements such as the following from Dr. Cook:

> I have personally cared for many cases of all of these

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[34] H.R. REP. 108-58 at 12.

[35] *See id.* at 14-19.

> disorders, and have never required any technique like partial birth abortion in order to accomplish delivery. Additionally, I have never had a colleague that I have known to have used the technique of partial birth abortion in order to accomplish delivery in this same group of patients. Moreover there are high profile providers of third trimester abortions who likewise do not use the technique of partial birth abortion. In the even rarer case of a severe maternal medical condition requiring early delivery, partial birth abortion is not preferred, and medical induction suffices without threatening future fertility. Again, the killing of the fetus is not required, only separation from the mother.[36]

In addition, Congress had statements from the AMA that the procedure "is not an accepted medical practice," and from Dr. Pamela Smith that physicians were horrified to know that such a procedure "was even legal."[37]

Such differences of opinion do not hamstring Congress in its efforts to regulate and protect the integrity of the medical profession. Instead, Congress is permitted to take sides in the debate and establish a regulation that best fulfills the legislature's goals to promote maternal health, preserve the integrity of the medical profession and promote respect for human life. The Act, which bans a procedure that is "disturbingly similar to the killing of a newborn, promotes a complete disregard for infant human life, and . . .further coarsens society to the humanity of, not only newborns, but

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[36] Cook, 14 ISSUES L. & MED. at 68.

[37] H.R. REP. 108-58 at 20.

all vulnerable and innocent human life"[38] is such a regulation. As this Court has established, Congress's decision must be given wide latitude, and "courts should be cautious not to rewrite legislation. . . ." *Marshall,* 414 US at 427.

CONCLUSION

Congress has appropriately banned a gruesome and inhumane procedure that is unrecognized as a valid abortion procedure by the medical community, poses health risks to the mother, blurs the line between abortion and infanticide and confuses the role of the physician in childbirth. Congress has fulfilled its duty to protect the integrity of the medical profession and its duty to preserve and promote life. Congress has defined the procedure with precision so as to clearly track the difference between it and the abortion procedures protected by *Roe v. Wade*. Finally, Congress has appropriately sided with the preservation of life by taking sides in a medical debate fraught with conflict and emotion.

For these reasons, the Ninth Circuit's decision invalidating the Act must be reversed.

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[38] *Id.* at 22-23.